



ANTHOLOGY OF
**CLINICAL
PSYCHIATRY**

Revision Compilations

FIRST EDITION

A Structured Reference of High-Frequency
Examination Topics



TABLES



CRITERIA



CLINICAL PEARLS

أكثر من 4000 تجميعية

More than 4000 compilations

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Introduction

It is a pleasure to introduce *Anthology of Clinical Psychiatry: Revision Compilations*, prepared by Dr Osama Kanaan, Specialist Psychiatrist. This substantial work reflects considerable academic effort, clinical experience, and a clear understanding of the needs of trainees and practitioners in psychiatry.

Psychiatry is a broad and continuously developing discipline. Its learners are required to integrate knowledge from psychopathology, psychopharmacology, neuroscience, psychology, epidemiology, ethics, research methodology, and clinical practice. The volume of information can be challenging, particularly for those preparing for professional examinations or seeking a rapid review of essential clinical concepts. This book responds to that challenge by presenting a wide range of high-frequency topics in a concise, organized, and readily accessible format.

The book brings together 156 compilations arranged in five major parts. These cover pharmacology and treatment, clinical science and epidemiology, psychotherapy and psychology, extended reference material, practical clinical charts, and diagnostic criteria. The use of comparative tables, key thresholds, concise summaries, and clinical pearls enables readers to identify important facts quickly and to revise complex material systematically.

A particular strength of this work is its practical orientation. Rather than relying on lengthy narrative discussions, Dr Kanaan has distilled extensive psychiatric knowledge into structured sections that facilitate rapid recall, comparison, and examination preparation. Topics such as treatments of choice, diagnostic durations, prognostic factors, adverse effects, drug interactions, emergency management, psychopathology, research methods, and DSM diagnostic criteria are brought together within a single reference.

The preparation of such a comprehensive compilation requires patience, accuracy, perseverance, and a genuine commitment to psychiatric education. Dr Kanaan deserves recognition for the time and effort invested in collecting, organizing, and presenting this extensive material. His work will be especially valuable to psychiatric residents, postgraduate students, examination candidates, and clinicians wishing to refresh their knowledge efficiently.

As psychiatric knowledge, clinical guidelines, diagnostic classifications, and prescribing recommendations continue to evolve, readers should use this book as a revision and educational resource while consulting current authoritative guidelines and primary references when making clinical decisions. This principle does not diminish the value of the book; rather, it places it appropriately within the framework of responsible clinical learning.

I congratulate Dr Osama Kanaan on completing this valuable educational contribution and commend his dedication to supporting the professional development of psychiatrists and mental-health practitioners. I hope that readers will find this anthology informative, practical, and stimulating, and that it will encourage them not only to succeed in their examinations but also to continue developing their clinical judgement and commitment to compassionate, evidence-based psychiatric care.

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DRUG OF CHOICE

First-line pharmacological (and, where relevant, definitive) treatments across psychiatric presentations, with special-population prescribing. Always integrate guidelines (NICE / APA / Maudsley) with comorbidity, tolerability, and prior response.

Mood, Psychosis & Anxiety

Clinical Problem	Drug / Treatment of Choice
First-episode schizophrenia	Second-generation antipsychotic (SGA)
Treatment-resistant schizophrenia	Clozapine (after ≥ 2 adequate trials, one an SGA)
Chronic, frequently hospitalized schizophrenia	Long-acting injectable (LAI) + assertive community treatment
Acute mania	Lithium or valproate ($\pm$ antipsychotic)
Bipolar maintenance / prophylaxis	Lithium (gold standard)
Bipolar depression	Quetiapine, olanzapine–fluoxetine combination, or Lumateperone, Lurasidone, Cariprazine $\pm$ lamotrigine
Rapid-cycling bipolar disorder	Valproate or lamotrigine (avoid antidepressant monotherapy)
Unipolar major depression	SSRI (first-line)
Psychotic depression	Antidepressant + antipsychotic, or ECT
Atypical depression	SSRI first-line; MAOI classically effective
Depression + prominent anxiety / GAD	SNRI (e.g., venlafaxine) or SSRI
Dysthymia / persistent depressive disorder	SSRI + psychotherapy
Seasonal affective disorder	Bright light therapy $\pm$ SSRI
Post-stroke depression	SSRI (e.g., citalopram, sertraline)
Antidepressant-induced sexual dysfunction	Switch to / augment with bupropion

Clinical Problem	Drug / Treatment of Choice
Antidepressant-induced hyperprolactinaemia	Consider mirtazapine
Generalized anxiety disorder	SSRI or SNRI
Panic disorder	SSRI (first-line)
Social anxiety disorder	SSRI or SNRI
OCD	SSRI (high dose) + ERP
Depression with marked obsessional features	SSRI, Clomipramine (classic)
PTSD	SSRI/SNRI; trauma-focused CBT/EMDR is psychotherapy of choice
Body dysmorphic disorder	SSRI (high dose)
Bulimia nervosa	Fluoxetine (60 mg – highest-evidence antidepressant in psychiatry)
Binge-eating disorder	Lisdexamfetamine; SSRI alternative

NOTE Fluoxetine is the antidepressant with the strongest evidence base in two settings outside adult depression: bulimia nervosa (60 mg) and child/adolescent depression.

NOTE Lithium is the only mood stabiliser shown to reduce suicide risk; it remains gold-standard for bipolar prophylaxis despite a narrow therapeutic index.

NOTE Clozapine is reserved for treatment resistance (failure of ≥ 2 antipsychotics) and uniquely reduces suicidality in schizophrenia — but requires mandatory FBC monitoring for agranulocytosis.

Child & Adolescent

Clinical Problem	Drug / Treatment of Choice
ADHD in children	Methylphenidate (stimulant first-line)
OCD in children	Sertraline or fluvoxamine
OCD + depression in children	Fluoxetine
Childhood / adolescent depression	Fluoxetine (SSRI with clear first-line evidence)
Tics / Tourette syndrome	Clonidine/guanfacine (mild); antipsychotic (severe)

Clinical Problem	Drug / Treatment of Choice
Childhood insomnia	Sleep hygiene; melatonin if needed
Selective mutism	Fluoxetine (+ behavioural therapy)
Irritability/aggression in autism	Risperidone or aripiprazole
Enuresis (nocturnal)	Enuresis alarm first-line; desmopressin short-term
Childhood body dysmorphic disorder	Fluoxetine

NOTE Fluoxetine is the only antidepressant first-line for paediatric depression; all SSRIs in under-18s carry a boxed warning for increased suicidal ideation — monitor closely after initiation.

NOTE In ADHD, stimulants (methylphenidate) are first-line; atomoxetine or guanfacine are non-stimulant alternatives when tics, misuse risk, or stimulant intolerance are concerns.

Neuropsychiatry & Older Adults

Clinical Problem	Drug / Treatment of Choice
Alzheimer's disease (mild–moderate)	Cholinesterase inhibitor (donepezil/rivastigmine/galantamine)
Alzheimer's disease (moderate–severe)	Memantine ($\pm$ cholinesterase inhibitor)
Dementia with Lewy bodies	Rivastigmine; avoid antipsychotics (severe sensitivity)
Vascular dementia	Aggressive vascular risk-factor control
Dementia with renal failure	Rivastigmine
Delirium (agitated, medically ill)	Low-dose haloperidol (treat the cause first)
Delirium in Parkinson's / DLB	Quetiapine (avoid high-potency D2 blockers)
Catatonia	Lorazepam (first-line); ECT if refractory
Stupor in schizophrenia	Lorazepam first-line, with ECT reserved for refractory or severe/life-threatening cases
Trigeminal neuralgia	Carbamazepine
Simple absence (petit mal) seizures	Ethosuximide

NOTE Antipsychotics are contraindicated as first-line in DLB — up to 50% show severe neuroleptic sensitivity (rigidity, irreversible parkinsonism, NMS-like reactions).

NOTE In delirium, haloperidol controls agitation but never treats the cause; always search for and correct the precipitant (infection, drugs, metabolic, hypoxia).

Sleep, Emergencies & Substance Use

Clinical Problem	Drug / Treatment of Choice
REM sleep behaviour disorder	Clonazepam or melatonin
Cataplexy in narcolepsy	Sodium oxybate
Excessive daytime sleepiness (narcolepsy)	Modafinil
Obstructive sleep apnoea	Nasal CPAP
Restless legs syndrome	$\alpha_2\delta$ ligands (gabapentin enacarbil / pregabalin) as first-line+ Dopamine agonist (pramipexole/ropinirole)
Sleep-related eating disorder	Topiramate (No established first-line)
Antipsychotic-induced weight gain	Metformin (adjunct) + lifestyle
Acute dystonia	IM/IV anticholinergic (procyclidine/benztropine)
Akathisia	Propranolol (or reduce dose)
Neuroleptic malignant syndrome	Stop antipsychotic; dantrolene/bromocriptine; supportive
Serotonin syndrome	Stop agent; supportive; cyproheptadine if severe
Lithium toxicity (severe)	Haemodialysis
Priapism (antipsychotic-induced)	Intracavernosal phenylephrine
Alcohol withdrawal	Long-acting benzodiazepine (chlordiazepoxide/diazepam) + thiamine
Wernicke's encephalopathy	Parenteral thiamine (before glucose)
Opioid dependence (maintenance)	Methadone or buprenorphine
Premature ejaculation	Dapoxetine / SSRI; behavioural techniques

NOTE Always give thiamine BEFORE glucose in suspected Wernicke's — a glucose load can precipitate or worsen encephalopathy in thiamine-deficient patients.

NOTE NMS vs serotonin syndrome: both cause hyperthermia and rigidity, but serotonin syndrome features clonus, hyperreflexia, and rapid onset (hours), whereas NMS evolves over days with 'lead-pipe' rigidity and bradyreflexia.

Prescribing in Special Populations

Population	Preferred Agents by Class
Pregnancy	Antipsychotic: olanzapine / haloperidol Antidepressant: sertraline (nortriptyline if TCA) Avoid: valproate, carbamazepine, paroxetine Avoid lithium if possible during first trimester; not absolutely contraindicated
Breastfeeding	Antipsychotic: olanzapine Antidepressant: sertraline Sedative: lorazepam Avoid: Lithium generally avoided, clozapine
Hepatic impairment	Antipsychotic: low-dose haloperidol / amisulpride / sulpiride Antidepressant: SSRI at reduced dose with careful monitoring citalopram (low starting dose) / sertraline Sedative: lorazepam / oxazepam / temazepam Mood stabiliser: lithium (renally cleared)
Renal impairment	Antipsychotic: haloperidol / olanzapine (low dose) Antidepressant: citalopram / sertraline Sedative: lorazepam Mood stabiliser: valproate (avoid lithium)
Epilepsy	Antipsychotic: Aripiprazole / haloperidol / sulpiride Antidepressant: SSRI (caution citalopram dose; avoid bupropion/clomipramine)
Cardiac (AF / QT risk)	Antipsychotic: aripiprazole Antidepressant: mirtazapine / sertraline Mood stabiliser: Valproate preferred; lithium with monitoring Dementia: rivastigmine
Learning disability	Antipsychotic: risperidone Self-injury: consider risperidone; review behavioural causes Antidepressant: SSRI

NOTE Valproate is contraindicated in women of childbearing potential unless pregnancy-prevention conditions are met — highest teratogenic risk of the mood stabilisers (neural tube defects, ~10% major malformation, neurodevelopmental harm).

NOTE Lithium clearance rises in pregnancy then falls abruptly at delivery — check levels frequently and reduce dose peripartum to avoid toxicity; it is linked to Ebstein's anomaly (absolute risk still low, ~1:1000).

NEUROTRANSMITTERS & NEUROCHEMISTRY

Core neurotransmitter and neuroendocrine changes underlying major psychiatric disorders and substances — the rational basis for psychopharmacology.

Disorder ↔ Neurotransmitter Map

Disorder / State	Key Neurochemistry
Schizophrenia	Dopamine: mesolimbic overactivity → positive symptoms; mesocortical underactivity → negative/cognitive Glutamate: NMDA hypofunction hypothesis Serotonin: 5-HT _{2A} activity (target of atypicals); GABA interneuron deficits
Depression	↓ Serotonin and noradrenaline (mood); ↓ dopamine (anhedonia, low motivation) + Neuroplasticity, BDNF, inflammation, glutamate
Bipolar disorder	Dopamine/glutamate dysregulation: ↑ dopamine in mania, ↓ in depression
Anxiety / GAD	↓ Serotonin & GABA, ↑ noradrenaline
Panic disorder	↓ GABA, ↑ noradrenaline; serotonin modulation (locus coeruleus hyperactivity)
Phobias	↓ Serotonin, ↑ noradrenaline
PTSD	↑ CRF, ↓ cortisol, ↑ NE & adrenaline → poor stress adaptation + exaggerated startle
OCD	Serotonergic dysfunction (basis for high-dose SSRI/clomipramine response)
Tourette's syndrome	Dopamine (primary); dopaminergic overactivity in basal ganglia
ADHD	Dopamine & noradrenaline hypofunction (fronto-striatal)

Disorder / State	Key Neurochemistry
Alzheimer's disease	↓ Acetylcholine (loss of nucleus basalis of Meynert; ↓ choline acetyltransferase) ↑ Glutamate excitotoxicity; ↓ NA, 5-HT, somatostatin
Delirium	↓ Acetylcholine + ↑ dopamine (core); ± ↑ glutamate, ↑ NE, altered 5-HT/GABA
Delirium tremens (alcohol withdrawal)	Locus coeruleus / noradrenergic hyperactivity; GABA–glutamate imbalance
Frontotemporal dementia	Cortical/striatal serotonergic deficit; cholinergic system relatively spared
Dementia with Lewy bodies	Cholinergic deficit MORE pronounced than in Alzheimer's
Idiopathic Parkinson's disease	Dopaminergic deficit MORE pronounced than in DLB
Parkinson's disease dementia	Ascending monoaminergic damage (DA, 5-HT, NA) + cortical cholinergic disruption
Huntington's disease	Selective loss of GABAergic (and cholinergic) neurons in striatum
REM sleep	Acetylcholine is the principal neurotransmitter
Anorexia nervosa	↑ Serotonin activity (↑ CSF 5-HIAA when weight-restored); ↓ dopamine, ↓ BDNF, ↓ leptin
Bulimia nervosa	5-HT dysregulation; ↓ CSF 5-HIAA/HVA, ↓ β-endorphin & CCK-8, ↑ AVP
Intermittent explosive disorder / impulsivity	↓ Serotonin (low CSF 5-HIAA)
Conduct disorder	Low CSF serotonin
Autism spectrum disorder	Hyperserotonaemia — raised whole-blood serotonin (most consistent finding) Excitatory–inhibitory imbalance (GABA/glutamate)
Chronic fatigue syndrome / fibromyalgia	Hypocortisolaemia (HPA-axis hypoactivity)

Disorder / State	Key Neurochemistry
Cocaine	Blocks reuptake of dopamine, NA, serotonin; ↑ ACTH/cortisol & LH/FSH; ↓ prolactin
MDMA (ecstasy)	Massive serotonin (and dopamine) release
Premenstrual syndrome	Altered serotonin sensitivity; ↓ β -endorphin; progesterone/oestrogen imbalance

NOTE Schizophrenia's four dopamine pathways: mesolimbic (↑ → positive symptoms), mesocortical (↓ → negative/cognitive), nigrostriatal (D2 block → EPSE), tuberoinfundibular (D2 block → hyperprolactinaemia).

NOTE Acetylcholine is the unifying thread of cognition: its deficit underlies both Alzheimer's (chronic) and delirium (acute) — hence anticholinergic drugs precipitate/worsen both.

NOTE The cholinergic vs dopaminergic contrast distinguishes Lewy-body disorders: DLB has the greater cholinergic loss; idiopathic Parkinson's has the greater dopaminergic loss.

NOTE Low CSF 5-HIAA (a serotonin metabolite) is the classic marker of impulsivity, aggression, and completed suicide — cuts across IED, conduct disorder, and personality pathology.

NOTE Counter-intuitive eating-disorder finding: serotonin activity is RAISED (not lowered) in weight-restored anorexia, possibly driving rigid, anxious, over-controlled feeding behaviour.

NOTE PTSD's neuroendocrine signature is paradoxically LOW cortisol with HIGH noradrenaline — distinguishing it from depression (where cortisol is typically high).

EEG FINDINGS

Characteristic electroencephalographic patterns across neuropsychiatric disease, epilepsy syndromes, and psychotropic drug effects — a key exam topic.

Neurodegenerative, Metabolic & Infective

Disease / State	EEG Finding
Creutzfeldt-Jakob disease (sporadic)	Periodic biphasic/triphasic sharp-wave complexes on slow background; with myoclonic jerks as disease progresses
Subacute sclerosing panencephalitis	Periodic complexes (long-interval, stereotyped bursts)
Hepatic encephalopathy	Triphasic waves; generalized slowing with posterior preservation

Disease / State	EEG Finding
Alzheimer's disease	Diffuse slowing, ↓ alpha & beta, ↑ theta & delta (may be normal early in ~6%)
Pick's / frontotemporal dementia	Often normal; less slowing than Alzheimer's
Vascular dementia	Asymmetry, localized slow waves, sparing of background
Huntington's disease	Low-voltage record (flattening), loss of alpha
Delirium	Diffuse slowing, ↓ alpha, ↑ theta & delta (correlates with severity)
Delirium tremens	Fast, hyperactive (low-voltage fast activity) — NOT slowing
Encephalopathy (general)	Diffuse slowing, triphasic waves, FIRDA (frontal intermittent rhythmic delta activity)
Herpes simplex encephalitis	Periodic lateralized epileptiform discharges (PLEDs), often temporal
Normal ageing (>60)	Slowing of alpha, ↑ theta (left temporal), ↑ anterior delta, ↓ beta (>80 yr)

NOTE Triphasic waves are the metabolic-encephalopathy signature (classically hepatic) — contrast with the PERIODIC sharp-wave complexes of CJD, the other great 'periodic' tracing.

NOTE Delirium tremens is the exception that proves the rule: most delirium shows slowing, but DT shows fast, low-voltage activity — mirroring its hyperadrenergic, hyperaroused state.

Epilepsy Syndromes

Syndrome	EEG Finding
Absence (petit mal) seizures	Generalized, bilateral, synchronous 3 Hz spike-and-wave
Generalized tonic-clonic	Generalized spikes / polyspikes (~25–30 Hz during seizure)
Partial (focal) epilepsy	Focal spikes
Juvenile myoclonic epilepsy	Generalized 4–6 Hz polyspike-and-wave

Syndrome	EEG Finding
Infantile spasms (West syndrome)	Hypsarrhythmia – chaotic high-voltage slow waves + asynchronous multifocal spikes
Lennox-Gastaut syndrome	Slow (<2.5 Hz) spike-and-wave; paroxysmal fast activity in sleep
Temporal lobe epilepsy	Anterior temporal spikes/sharp waves

NOTE Memorize the trio of childhood patterns: 3 Hz spike-and-wave = absence; hypsarrhythmia = infantile spasms (West); slow <2.5 Hz spike-and-wave = Lennox-Gastaut.

Drug & Substance Effects

Agent	EEG Effect
Cannabis	Mild ↑ alpha + increased theta in some studies
Stimulants (cocaine, nicotine)	Cocaine / amphetamines : ↑ Beta activity (fast activity), ↓ alpha Nicotine : ↓ alpha + ↑ beta (alertness)
CNS depressants (alcohol, opioids)	Generalized slowing (↑ theta/delta) ± ↓ alpha
Benzodiazepines	↑ Beta, ↓ alpha
Barbiturates	Dose-dependent slowing + beta increase early
Lithium	Diffuse slowing; in toxicity: triphasic waves, paroxysmal abnormalities
Tricyclic / antidepressants	↓ Beta, ↑ all others; overdose → widespread fast activity & spikes
Antipsychotics (typical/phenothiazine)	↑ Voltage, slow alpha, ↓ beta
Antipsychotics (atypical)	Variable; clozapine has the most significant effect (lowers seizure threshold)
Anticonvulsants	Typically little/no change on background
ECT (post-ictal)	Transient slowing; resolves over weeks

NOTE Simple rule: stimulants & cannabis ↑ alpha; depressants ↓ alpha; benzodiazepines & barbiturates ↑ beta. Clozapine is the antipsychotic most likely to cause EEG changes and lower seizure threshold.

Primary Psychiatric Disorders

Disorder	EEG Finding
Schizophrenia	↓ Alpha power, ↑ reactivity, ↑ frequency variability, higher inter-hemispheric symmetry
ADHD	↑ Theta/beta ratio (↑ slow waves, ↓ fast frontally); arousal dysregulation

NOTE ADHD's elevated theta/beta ratio was once proposed as a diagnostic biomarker (the basis of an FDA-cleared device), though it is not specific enough to diagnose on its own.

PSYCHOTHERAPY OF CHOICE

The best-evidenced psychological treatment for each disorder. In most conditions psychotherapy is combined with pharmacotherapy; the table lists the modality of first choice.

Anxiety & Trauma-Related

Disorder	Psychotherapy of Choice
OCD	Exposure and response prevention (ERP) – first-line behavioural therapy
OCD in children	CBT (with ERP)
Anxiety disorders (general)	CBT – most effective across the anxiety spectrum
Specific phobia	In vivo (graded) exposure therapy
Phobic anxiety / agoraphobia	Graded exposure, relaxation, systematic desensitization
Social phobia	CBT
Panic disorder	CBT (cognitive restructuring + interoceptive exposure)
GAD	CBT
PTSD	Trauma-focused CBT or EMDR (first-line)
Acute stress / prevent PTSD	Brief trauma-focused CBT (not single-session debriefing)
Separation anxiety disorder	CBT and play therapy

NOTE All anxiety disorders share CBT as the core treatment, but the active ingredient differs: ERP for OCD, in vivo exposure for phobias, interoceptive exposure for panic, and trauma-focused CBT/EMDR for PTSD.

NOTE Single-session psychological debriefing after trauma is NOT recommended – it may increase PTSD risk. Use brief, structured trauma-focused CBT for those with persistent acute symptoms.

Mood & Adjustment

Disorder	Psychotherapy of Choice
Mild–moderate depression	CBT, IPT, behavioural activation (psychotherapy first-line)
Depression in children	CBT or IPT (± family therapy)
Bipolar depression / maintenance	Adjunctive psychoeducation, CBT, family-focused, IPSRT
Adjustment disorder	Supportive psychotherapy / problem-solving
Grief / bereavement	Supportive therapy
Dysthymia / persistent depression	CBT / IPT (long-term)

NOTE In mild-to-moderate depression, psychotherapy is first-line and equivalent to medication; combination therapy outperforms either alone in moderate-to-severe or recurrent illness.

Personality & Dissociative

Disorder	Psychotherapy of Choice
Borderline personality disorder	Dialectical behaviour therapy (DBT)
Antisocial personality disorder	Moral reasoning + CBT-based offending programs (limited evidence) Group-based cognitive
Self-harm / suicidality (incl. prison)	DBT (best evidence)
Dissociative disorders	Psychotherapy (psychodynamic / phased trauma work)
Dissociative fugue	Psychodynamic psychotherapy supportive + trauma-focused therapy (if trauma-related)

NOTE DBT is the flagship therapy for emotional dysregulation and self-harm in borderline personality disorder – it is also the best-evidenced approach to self-harm in custodial settings.

Eating Disorders

Disorder	Psychotherapy of Choice
Anorexia nervosa (adolescents)	Family-based therapy (Maudsley model)
Bulimia nervosa	CBT-ED (enhanced CBT)
Binge-eating disorder	CBT or behavioural/IPT approaches

NOTE Family-based (Maudsley) therapy is first-line for adolescent anorexia; CBT-ED is first-line for bulimia nervosa and binge-eating disorder.

OCD-Spectrum & Impulse Control

Disorder	Psychotherapy of Choice
Hoarding disorder	CBT (motivational + sorting/decision skills)
Trichotillomania (hair-pulling)	Habit-reversal training
Skin-picking (excoriation)	Habit-reversal training
Tics of Tourette syndrome	Habit-reversal / comprehensive behavioural intervention (CBIT); ERP
Kleptomania	CBT with relapse prevention / CBT for impulse control
Pathological gambling	motivational interviewing + CBT combination is first-line

NOTE Habit-reversal training is the unifying behavioural treatment for the body-focused repetitive behaviours: trichotillomania, skin-picking, and tics.

Child & Adolescent

Parent Management Training (PMT) is primary first-line (stronger than CBT alone)

Disorder	Psychotherapy of Choice
ODD	Parent management training + individual/CBT
Conduct disorder	Parent-management training; multisystemic therapy (strongest evidence adolescents)
Autism spectrum disorder	Early behavioural intervention (e.g., ABA) + educational/social-skills training
ADHD (behavioural component)	Behavioural parent training (with medication)
Enuresis	Bell-and-pad (alarm) conditioning – most effective

Disorder	Psychotherapy of Choice
Encopresis	Behavioural therapy + family intervention
School refusal	Early graded return to school (Kennedy approach) + CBT
Stereotypic movement disorder	Behavioural therapy
Adolescent delinquency / substance use	Family therapy / multisystemic therapy

NOTE Parent-management training is the best-established intervention for disruptive behaviour (ODD, conduct disorder); the bell-and-pad alarm achieves dryness in >50% of enuresis cases.

Sexual Disorders

Disorder	Technique of Choice
Premature ejaculation	'Stop-start' (Semans) / squeeze (Masters & Johnson) technique
Anorgasmia	Directed masturbation training
Erectile dysfunction (couple)	Sensate focus / couple therapy
Fetishism / paraphilias	Orgasmic reconditioning + covert sensitization
Compulsive sexual behaviour	12-step group + CBT

Psychosis, Somatic & Substance Use

Disorder	Psychotherapy of Choice
Schizophrenia (persistent psychosis)	CBT for psychosis (CBTp) adjunct to antipsychotic
Schizophrenia (functional decline)	Cognitive remediation therapy (CRT)
Frequently hospitalized chronic schizophrenia	Assertive community treatment (ACT)
Chronic fatigue syndrome	CBT ($\pm$ graded exercise, individualized)
Hypochondriasis / illness anxiety	CBT
Somatic symptom disorder	CBT

Disorder	Psychotherapy of Choice
Migraine (behavioural)	Biofeedback / relaxation
Cocaine use disorder	Contingency management = strongest evidence
Mild alcohol dependence	CBT / motivational interviewing
HIV-related depression	Interpersonal therapy (IPT)
Learning disability (behavioural)	Behavioural therapy (relaxation, skills training, chaining)
Depression in MS / chronic illness	CBT

NOTE CBT for psychosis benefits patients with distressing, medication-resistant positive symptoms and low delusional conviction; it is least helpful in acute psychosis or prominent negative symptoms.

TIME NEEDED FOR DIAGNOSIS

Minimum symptom durations and frequency thresholds required for diagnosis (predominantly DSM-5-TR, with ICD differences noted). A classic source of exam questions.

Mood Disorders

Diagnosis	Required Duration
Major depressive episode	≥ 2 weeks
Manic episode	≥ 1 week (or any duration if hospitalization needed)
Hypomanic episode	≥ 4 consecutive days
Persistent depressive disorder (dysthymia)	≥ 2 years (≥ 1 year in children/adolescents)
Cyclothymia	≥ 2 years (≥ 1 year in children/adolescents)
Seasonal pattern (ICD)	Seasonal episodes ≥ 3 consecutive years
Premenstrual dysphoric disorder	Most cycles over the preceding year

NOTE Anchor the mood durations: depression ≥ 2 weeks, mania ≥ 1 week, hypomania ≥ 4 days, dysthymia/cyclothymia ≥ 2 years (halve the chronic ones to ≥ 1 year in youth).

Psychotic Disorders

Diagnosis	Required Duration
Schizophrenia (DSM)	≥ 6 months total (≥ 1 month active-phase symptoms)
Schizophreniform disorder	1–6 months
Brief psychotic disorder	1 day to < 1 month
Schizoaffective disorder	≥ 2 weeks of psychosis without prominent mood symptoms
Delusional disorder	≥ 1 month

NOTE The psychosis duration ladder: brief psychotic < 1 month → schizophreniform 1–6 months → schizophrenia ≥ 6 months. Only schizophrenia requires functional decline.

Anxiety, Trauma & Somatic

Diagnosis	Required Duration
Generalized anxiety disorder	≥ 6 months
Social anxiety / specific phobia	≥ 6 months
Separation anxiety disorder	≥ 4 weeks (children); ≥ 6 months (adults)
Selective mutism	≥ 1 month (not limited to first month of school)
PTSD	Symptoms > 1 month (post-trauma)
Acute stress disorder	3 days to 1 month
Adjustment disorder	Within 3 months of stressor; ≤ 6 months after stressor ends
Illness anxiety disorder	≥ 6 months
Somatic symptom disorder	Typically > 6 months (persistent state)
Body dysmorphic disorder	No minimum duration specified

NOTE Acute stress disorder spans 3 days–1 month; once symptoms persist beyond 1 month the diagnosis becomes PTSD. Most adult anxiety disorders share the ≥ 6-month threshold.

Feeding & Eating

Diagnosis	Required Duration / Frequency
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Diagnosis	Required Duration / Frequency
Bulimia nervosa	≥ 1×/week for 3 months (binge + compensatory)
Binge-eating disorder	≥ 1×/week for 3 months
Anorexia (sub-type window)	Behaviour over the last 3 months defines restricting vs binge-purge type
Pica	≥ 1 month
Rumination disorder	≥ 1 month
Avoidant/restrictive food intake (ARFID)	No fixed duration; persistent failure to meet needs

NOTE Bulimia and binge-eating disorder share the same threshold: at least once weekly for three months.

Neurodevelopmental & Disruptive

Diagnosis	Required Duration
ADHD	≥ 6 months; several symptoms before age 12
Oppositional defiant disorder	≥ 6 months
Conduct disorder	≥ 12 months (≥ 1 criterion in past 6 months)
Enuresis	≥ 2×/week for 3 months (or marked distress); age ≥ 5 yr
Encopresis	≥ 1×/month for 3 months; age ≥ 4 yr
Tourette's disorder	Motor + vocal tics, > 1 year
Persistent (chronic) tic disorder	Single type, > 1 year
Provisional tic disorder	< 1 year
Stereotypic movement disorder	Onset in early developmental period; persistent
Developmental coordination disorder	Onset in early development (not before reliably assessable)
Stuttering (childhood-onset)	Persistent (≥ 3 months commonly used)

NOTE Tic duration defines the diagnosis: < 1 year = provisional; > 1 year single-type = persistent; > 1 year motor + vocal = Tourette's.

Sleep–Wake

Diagnosis	Required Duration / Threshold
Insomnia disorder (DSM)	≥ 3 nights/week for ≥ 3 months
Insomnia (ICD)	Nearly every night for ≥ 1 month
Hypersomnolence	≥ 3×/week for ≥ 3 months
Narcolepsy	≥ 3×/week over past 3 months
Restless legs syndrome	≥ 3×/week for ≥ 3 months
Obstructive sleep apnoea	≥ 5 obstructive events/hour on polysomnography
Central sleep apnoea	≥ 5 central apneas/hour on polysomnography

Sexual, Gender & Other

Diagnosis	Required Duration
Sexual dysfunctions (most)	≥ 6 months and on ≥ 75% of occasions
Paraphilic disorders (most)	≥ 6 months
Pedophilic disorder	≥ 6 months; individual ≥ 16 yr and ≥ 5 yr older than child
Gender dysphoria	≥ 6 months
Diagnosis	Required Duration
Chronic fatigue syndrome	≥ 6 months of unexplained fatigue
Neurasthenia (ICD)	≥ 3 months
Post-stroke depression	Most cases within 6 months of stroke
Postpartum (peripartum) depression	Onset in pregnancy or within 4 weeks (DSM); up to ~3–6 months clinically
Postpartum psychosis	Typically within 2 weeks of delivery (psychiatric emergency)
Conversion / factitious disorder	No minimum duration specified

NOTE Postpartum psychosis is the obstetric-psychiatric emergency: it typically erupts within the first 2 weeks postpartum and carries high relapse risk in bipolar disorder.

GOOD PROGNOSIS

Factors associated with favourable outcome across psychiatric disorders. Recurring themes – acute onset, clear stressor, good premorbid function, early treatment – appear throughout.

Good Prognostic Factors by Disorder

Disorder	Factors Favouring Good Prognosis
Schizophrenia	Good premorbid function, acute/late or sudden onset, clear precipitant, mood symptoms, family history of mood disorder, paranoid subtype, married, female, few negative symptoms, early treatment, developing-country setting, Acute onset
Delusional disorder	Female, onset < 30 yr, sudden onset, short duration, good premorbid function, presence of a precipitant, No hallucinations
Major depression	Acute onset, clear precipitant, good premorbid function, no psychosis, early treatment, good support
Old-age (late-life) depression	Onset < 70 yr, shorter illness, no physical illness, good previous adjustment and prior recovery
Bipolar disorder	Manic (vs depressive/mixed) episodes, good treatment adherence, fewer episodes, good inter-episode function Euthymic long periods Pure episodes No substance use
Panic disorder	Good premorbid function, brief symptom duration, low baseline attack frequency, resolution of stressors, female No agoraphobia
OCD	Good social/occupational adjustment, a precipitating event, episodic course, absence of compulsions; obsession content does NOT affect prognosis, Good insight
Conversion disorder	Acute onset, identifiable stressor, short onset-to-treatment interval, good premorbid intelligence/health

Disorder	Factors Favouring Good Prognosis
Hypochondriacal disorder	Good past health, high socioeconomic status, sudden onset of hypochondriacal ideas, comorbid treatable anxiety/depression
Illness anxiety disorder	Higher socioeconomic status, treatment-responsive anxiety/depression, no comorbid medical or personality disorder
Factitious disorder	Comorbid mood/anxiety/substance disorder predicts BETTER outcome; comorbid antisocial PD predicts worse
Anorexia nervosa	Onset < 15 yr, higher weight at onset/presentation, treatment within 3 months, recovery within 2 years, supportive family, good motivation, good childhood adjustment
Paraphilias	Better with later onset, less frequency, presence of guilt, ongoing normal sexual activity, self-referral (worse if substance use, early onset, legal referral)
Chronic fatigue syndrome	No strong physical attribution, less severe baseline fatigue, younger age; worse if psychological comorbidity or belief that rest is curative
Alzheimer's disease	Later onset (> 65 yr), female, absence of behavioural symptoms, no depressive episodes
Normal pressure hydrocephalus	Full clinical triad, short history, identifiable cause
Antisocial / dissocial PD (therapy response)	Presence of anxiety, comorbid depression, comorbid psychosis (non-organic)
Alcohol dependence	Motivation to change, supportive relationship, employment, treatable comorbidity, accepting appropriate goal, AA involvement
Erectile dysfunction (couple therapy)	Good marital state, good prior communication & sexual adjustment, partner interest, no psychiatric history in partner, early homework engagement

NOTE A universal prognostic rule of thumb: acute/sudden onset, a clear precipitating stressor, good premorbid functioning, and early treatment predict good outcome across almost every psychiatric disorder.

NOTE Schizophrenia's strongest good-prognosis markers are good premorbid function, prominent mood symptoms, and acute onset – the more the picture resembles a mood disorder, the better the outlook.

NOTE In OCD, an episodic course and a precipitating event favour recovery, while the CONTENT of obsessions is unrelated to prognosis – a frequently tested point.

NOTE Comorbidity cuts both ways in factitious disorder: a comorbid mood/anxiety/substance disorder predicts a BETTER outcome, whereas antisocial personality disorder predicts a worse one.

NOTE In anorexia, the best single predictors are young age at onset, higher weight at presentation, and early treatment – long duration before treatment is the key adverse factor.

INCREASED RISK (RELATIVE RISKS)

Relative-risk and 'how many times' multipliers across psychiatry - suicide, familial, drug-induced, epidemiological, and cognitive - capturing the full source set with additions. Figures are approximate and study-dependent.

Suicide & Self-Harm Risk

Condition	Relative Risk
Anorexia nervosa	Suicide ~200x general population (overall mortality ~6x; ~1 in 5 deaths from suicide); ~20x in some series
Alcohol dependence	Suicide ~6-12x general population (regular alcohol users: lifetime attempt rate ~7% vs ~1%)
Drug dependence/abuse	Suicide ~15x; heavy drinkers ~3.5x; alcohol use disorder ~10x
Temporal lobe epilepsy / epilepsy + depression	Suicide ~25x when clinical depression present; epilepsy overall ~3-5x (self-harm over-represented 5-7x)
Deliberate self-harm (DSH)	Suicide within 1 yr ~0.7% (66x general population; men 1.1%, women 0.5%); ~1% die within 24 months (50-100x)
Previous suicide attempt	Risk ~40x higher

Condition	Relative Risk
Traumatic brain injury	Suicide risk ~9x; HIV-positive status ~2x
Bipolar disorder	Suicide ~15x general population (rate ~10-19%)
Schizophrenia	Lifetime suicide ~6%, almost 10x general population
Huntington's disease	Suicide ~4x (unaffected family members also raised)
Mental health service users	Suicide ~1 in 1000 (~10x general population)
Specific phobia	Up to 60% more likely to attempt suicide
Drowning risk in drinkers	~3.5x higher

NOTE The headline suicide multipliers: anorexia nervosa ~200x, alcohol dependence ~60-120x, deliberate self-harm ~66x (within 1 year), and temporal lobe epilepsy with depression ~25x — anorexia carries the single highest relative risk in psychiatry.

Familial & Genetic Risk

Condition	Relative Risk
Alcoholism (family history)	1st + 2nd degree relative ~4x (167%); 1st-degree ~2x (86%); 2nd/3rd-degree ~1.5x (45%); child of alcoholic parent 4-10x
Alcoholism (early drinking / stressors)	Drinking before age 15 ~4x; severe childhood abuse up to ~7x
Autism (sibling)	Sibling recurrence ~3-5% (~10x; some estimates ~50x); two affected children ~25-30% (~300x)
Alzheimer's disease (1st-degree relative)	~3-4x (predicted lifetime risk ~15-19% vs ~5% controls)
Night terrors	~10x increase in 1st-degree relatives
OCD	Adult-onset proband ~2x in relatives; childhood-onset ~10x
Major depressive disorder	1st-degree relatives ~2-4x; females ~1.5-3x males; 18-29 yr ~3x vs 60 yr

Condition	Relative Risk
Hyperkinetic disorder	~5x greater risk for antisocial behaviour, substance abuse & other disorders

NOTE Autism sibling risk is dramatic: ~3-5% recurrence (~10x population) after one affected child, rising to ~25-30% (~300x) after two — one of the steepest familial gradients in psychiatry.

Drug-Induced & Teratogenic Risk

Drug / Exposure	Relative Risk
Antipsychotics & stroke (elderly)	Atypicals ~2.3x stroke (~5.9x if dementia); at least ~2x → no longer used in dementia
Lithium malformations	All malformations ~3x; cardiac ~8x; Ebstein's anomaly 10-20x (absolute risk ~1:1000)
Sodium valproate	Neural tube defect 1-2%; spina bifida ~10x; cardiac defects (VSD, pulmonary stenosis) ~4x
Citalopram in pregnancy	Septal heart defects ~2-2.5x; persistent pulmonary hypertension of newborn ~6x
SSRIs in late pregnancy	Persistent pulmonary hypertension ~2.5x (low base rate ~1-2/1000)
Antipsychotics in pregnancy	~2x gestational diabetes
Stopping antidepressants in pregnancy	~5x more likely to relapse than those who continue
Tardive dyskinesia (older antipsychotics, elderly)	~5-6x increased
Topiramate	Kidney stones ~10x (~1.9% of exposed adults)
Valproate + lamotrigine	Valproate raises lamotrigine levels > 2x
Ziprasidone with food	Bioavailability ~2x; food increases absorption

NOTE Teratogenic multipliers to memorise: lithium raises Ebstein's anomaly 10-20x (cardiac malformation ~8x), and valproate raises spina bifida ~10x — though absolute risks remain modest.

NOTE Antipsychotics roughly double stroke risk in the elderly (rising to ~6x in dementia), which is why the Committee on Safety of Medicines advised against their use for BPSD.

Epidemiological & Social Risk

Factor	Relative Risk
Schizophrenia (urban birth)	~2x vs rural-born
Schizophrenia (migrants)	Incidence ~3-5x; 2nd-generation relative risk ~4.5x
AESOP study	Schizophrenia ~9x in African-Caribbean, ~6x in Black African vs White British
Schizophrenia + learning disability	~3x (prevalence ~3-3.5%)
Schizophrenia mortality (SMR)	SMR ~2.5-2.6 (premature death ~2-3x)
Cannabis & schizophrenia (Dunedin)	Use at age 15 ~4.5x; at age 18 ~1.7x
Prisoners	Psychosis & major depression ~20x; antisocial PD ~10x; psychotic disorders in prison 10-20x
Intellectual handicap & offending (Hodgins)	Men ~3x offend, ~5x violent; women ~4x offend, ~25x violent
Mental illness & victimisation	Violent assault ~5x (40% of SMI victims of crime/year vs 14%)
Postpartum psychosis	~100x higher in bipolar or prior postpartum psychosis (vs 1-2/1000 baseline)
Bariatric surgery candidates	Psychotropic prescription ~6x general population
Metabolic syndrome (depression)	~2.4x (41% vs 17%); CATIE schizophrenia: women ~3x, men ~2x controls
Depression in coronary heart disease	~2-3x general population
Late-life depression (medically ill)	~2-3x more common

NOTE The AESOP study quantified migration as a major psychosis risk: schizophrenia incidence ~9x in African-Caribbean and ~6x in Black African groups versus White British — with urban birth independently doubling risk.

NOTE The Dunedin cohort showed cannabis timing matters: use at 15 raised schizophrenia risk ~4.5x versus ~1.7x at 18 — evidence for adolescent neurodevelopmental vulnerability.

Cognitive, Delirium & Comorbidity Risk

Condition	Relative Risk
Delirium → dementia	Patients with delirium ~3x more likely to develop dementia
Delirium in ICU	Affects 70-80%; ~10x cognitive impairment at discharge, ~3x mortality
Delirium & institutionalisation	~3x increased in patients ≥ 65 with delirium
Parkinson's + dementia & delirium	~2x more likely to develop delirium on antiparkinsonian agents
Parkinson's disease dementia	Dementia in 15-20% of PD vs 5-10% age-corrected population
MCI → dementia (hippocampal atrophy)	~4x higher conversion over 5 years
Hypochondriasis	~3x more likely to have a personality disorder

NOTE Delirium is far from benign: it independently predicts a ~3x risk of later dementia and, in ICU, a ~3x mortality with ~10x cognitive impairment at discharge.

NEUROANATOMICAL & IMAGING CHANGES (COMPREHENSIVE)

Structural, functional, and neuropathological brain changes across psychiatric and neurological disorders — capturing the full source set with additions. A detailed neuroimaging and neuropathology reference.

Dementias & Neurodegeneration

Condition	Neuroanatomical / Imaging Changes
Alzheimer's disease	Macro: diffuse cortical atrophy, flattened sulci, enlarged lateral & 3rd ventricles, ↓ brain weight, medial temporal/hippocampal atrophy. Micro: senile (neuritic) plaques, neurofibrillary tangles, reactive astrogliosis, granulovacuolar degeneration, ↓ dendritic branching. PET: ↓ parietotemporal O2/glucose; SPECT: ↓ parietotemporal perfusion

Condition	Neuroanatomical / Imaging Changes
Pick's disease / FTL	Asymmetrical frontal & temporal atrophy (occipital/parietal spared), 'knife-blade' gyri, enlarged ventricles; frontal/temporal hypoperfusion & hypometabolism
Vascular dementia	Macro/microscopic infarcts, subcortical ischaemic change, periventricular white-matter lesions; asymmetry with preserved background
Huntington's disease	Marked atrophy of caudate head & putamen, 'box-car' ventricles, generalised neuronal loss (worst over frontal lobes)
General paresis of the insane (GPI)	Cerebral atrophy + meningeal thickening, neuronal loss, astrocytosis; iron pigment in microglia/perivascular spaces (specific); spirochetes in cortex in ~50%
Punch-drunk / dementia pugilistica	Septum pellucidum perforation, cerebral atrophy, ventricular enlargement, corpus-callosum thinning, scarring; neuronal loss + neurofibrillary tangles (~15% of boxers after 12–16 yr)
Wernicke's encephalopathy	Gliosis & petechial haemorrhages periventricular/periaqueductal — mammillary bodies, hypothalamus, mediodorsal thalamus, colliculi, midbrain tegmentum
Marchiafava-Bignami syndrome	Demyelination of corpus callosum & adjacent white matter (malnourished alcoholics, M > F)
Herpes simplex encephalitis	Signal change & swelling in the temporal lobes

NOTE Alzheimer macro-anatomy (diffuse atrophy, flattened sulci, enlarged ventricles, hippocampal atrophy) pairs with micro-hallmarks (plaques, tangles, granulovacuolar degeneration); HMPAO-SPECT shows parietotemporal hypoperfusion and is NICE-recommended to differentiate AD/VaD/FTD.

NOTE Two atrophy patterns are spot-diagnosis shortcuts: 'knife-blade' frontotemporal gyri → Pick's, and caudate atrophy with 'box-car' ventricles → Huntington's.

Psychosis & Mood

Disorder	Neuroanatomical / Imaging Changes
Schizophrenia	Lateral & 3rd ventricle enlargement, ↓ white & grey matter, ↓ medial temporal/hippocampus/amygdala, ↓ prefrontal volume, INCREASED basal ganglia volume; ↓ 5-HT2A in PFC; hypofrontality (↓ DLPFC); striatal hyperdopaminergia; ABSENCE of gliosis; reversed planum temporale asymmetry; abnormal connectivity
Depression	↑ White-matter & periventricular hyperintensities, ENLARGED amygdala, enlarged lateral ventricles (late-onset), ↓ hippocampus (unipolar), ↓ basal ganglia & caudate, ↓ subgenual PFC grey matter, ↓ DLPFC blood flow
Late-onset depression	↓ Caudate volume, vascular disease, ↓ hippocampus, ↑ ventricles, ↓ frontal & temporal grey matter
Bipolar disorder	↓ Subgenual PFC grey matter (shared with unipolar); white-matter hyperintensities

NOTE Schizophrenia's signature combines ventricular enlargement and reduced temporal/prefrontal volume with INCREASED basal ganglia volume, functional hypofrontality, and an ABSENCE of gliosis — a neurodevelopmental rather than neurodegenerative pattern.

NOTE In depression the amygdala is ENLARGED (not reduced) while hippocampal volume falls in unipolar illness — a contrast examiners exploit.

Anxiety, OCD, Trauma & Personality

Disorder	Neuroanatomical / Imaging Changes
OCD	PET: HYPERmetabolism & ↑ blood flow in frontal lobes, cingulum, basal ganglia, orbitofrontal gyrus; ↓ caudate volume bilaterally; ↑ grey & ↓ white matter; caudate atrophy → box-car ventricles

Disorder	Neuroanatomical / Imaging Changes
Panic disorder	Temporal-lobe (esp. hippocampus) involvement, right temporal cortical atrophy; cerebral vasoconstriction (PET); NO increased basal ganglia flow
PTSD	↓ Medial PFC & anterior cingulate activity with ↑ amygdala (vmPFC fails to inhibit amygdala); amygdala & hippocampus implicated; low ambient cortisol ('adrenal exhaustion'); ↓ hippocampal volume
Borderline personality disorder	↓ Hippocampal volume, hyperactive HPA axis, ↓ CSF 5-HIAA (impulsivity), ↓ frontal metabolism, ↑ bilateral amygdala activity, orbitofrontal abnormality → ↓ amygdala modulation
Antisocial personality disorder	↓ Temporal-lobe volume (violence/sexual aggression), ↓ CBF in PFC/orbitofrontal/amygdala (↓ amygdala CBF → callous-unemotional trait)

NOTE OCD shows **HYPER**metabolism (not hypo-) in the orbitofrontal-caudate circuit with reduced caudate volume — the overactive loop normalised by SSRIs and CBT.

NOTE PTSD's most replicated functional finding is ventromedial PFC hypo-responsivity failing to inhibit an overactive amygdala — underlying impaired fear extinction.

Neurodevelopmental & Genetic Syndromes

Disorder	Neuroanatomical / Imaging Changes
ADHD	↓ Total brain volume, ↓ corpus callosum & cerebellum, ↓ anterior cingulate/thalamus/hippocampus/globus pallidus/caudate, ↑ slow-wave EEG, delayed posterior→anterior cortical maturation
Autism spectrum disorder	↑ Brain size/early overgrowth (occipital > parietal > temporal; frontal spared), ↑ lateral & 4th ventricles, hypoplasia of cerebellar vermis lobules VI/VII, abnormal Purkinje cells, gyrification defects; ~⅓ raised plasma serotonin

Disorder	Neuroanatomical / Imaging Changes
Fragile X syndrome	Enlarged ventricles, hippocampus & caudate; REDUCED posterior cerebellar vermis; enlarged 4th ventricle
Fetal alcohol syndrome	Microcephaly, partial/complete agenesis of corpus callosum, cerebellar hypoplasia; impaired fine motor, neurosensory hearing loss, poor tandem gait
Down syndrome	Total brain volume loss, ↓ grey matter, ↓ left hippocampus & amygdala, larger ventricles, mesial temporal shrinkage, 3rd ventricular enlargement
Velocardiofacial syndrome (22q11)	High incidence of cavum septi pellucidi, brain atrophy & asymmetry, abnormal white-matter tracts

NOTE Autism shows early brain OVERgrowth (greatest occipital/parietal/temporal, frontal spared) with cerebellar vermis hypoplasia (lobules VI/VII) and reduced Purkinje cells.

Behavioural, Ageing & Other

Condition	Neuroanatomical / Imaging Changes
Internet addiction	↓ Grey matter in left anterior & posterior cingulate; gaming activates right OFC (compulsion), nucleus accumbens (motivation), DLPFC (impulse control), caudate (compulsive behaviour)
Pathological gambling	Blunted mesolimbic-prefrontal activation to non-specific rewards; ↑ activation to gambling cues
Anorexia nervosa	↑ Ventricular/brain ratio (pseudatrophy) secondary to starvation — reversible with weight gain
Delirium	Reticular formation (attention/arousal); dorsal tegmental pathway (mesencephalic RF → tectum/thalamus); alcohol-withdrawal → locus coeruleus hyperactivity

Condition	Neuroanatomical / Imaging Changes
Delusions	Lesions of basal ganglia & limbic system
Normal ageing	Brain volume ↓ 5% (30–70 yr), 10% by 80, 20% by 90; ↑ CSF & ventricles, ↓ cortical grey matter & frontal blood flow; Lewy bodies, Hirano bodies, lipofuscin, some plaques. IQ peaks ~25, plateaus to 60–70; verbal abilities preserved
HIV	Progressive multifocal leukoencephalopathy (PML) on MRI — HIV accounts for ~85% of PML; AIDS-defining

NOTE Anorexia produces reversible 'pseudatrophy' (raised ventricle-to-brain ratio from starvation) that recovers with weight restoration — distinguishing it from fixed neurodegenerative atrophy.

CHROMOSOMES & PSYCHIATRIC DISORDERS (COMPREHENSIVE)

Chromosomal associations of psychiatric and neurogenetic disorders, presented both by chromosome and as a reverse disorder-to-chromosome lookup - capturing the full source set with corrected nomenclature and additions.

By Chromosome (1-22)

Chromosome	Associated Disorders
Chromosome 1	Schizophrenia, Alzheimer's disease, Anorexia nervosa
Chromosome 2	Autism, OCD
Chromosome 3	Bipolar affective disorder, Major depressive disorder
Chromosome 4	Huntington's disease, Hurler syndrome, Hoarding, Alcoholism
Chromosome 5	Cri du chat syndrome, Sotos syndrome, Hoarding, ASD
Chromosome 6	Schizophrenia, Specific reading disorder (dyslexia)
Chromosome 7	Anxiety, Schizophrenia, Williams syndrome, Autism
Chromosome 8	Schizophrenia, Cohen syndrome

Chromosome	Associated Disorders
Chromosome 9	Tuberous sclerosis, Dystonia musculorum deformans, OCD, Friedreich's ataxia, Cornelia de Lange syndrome
Chromosome 10	(no classic psychiatric association listed)
Chromosome 11	Acute intermittent porphyria
Chromosome 12	Phenylketonuria, Noonan syndrome
Chromosome 13	Anxiety, Schizophrenia, Wilson's disease, Patau syndrome (trisomy 13)
Chromosome 14	Alzheimer's disease (presenilin-1)
Chromosome 15	Angelman syndrome, Prader-Willi syndrome
Chromosome 16	Tuberous sclerosis
Chromosome 17	Frontotemporal dementia (Pick's), Hoarding, Smith-Magenis syndrome, Charcot-Marie-Tooth, Neurofibromatosis type 1
Chromosome 18	Bipolar affective disorder, Tourette's syndrome, Edwards syndrome (trisomy 18), focal/segmental dystonia
Chromosome 19	Alzheimer's disease (ApoE), CADASIL, Migraine
Chromosome 20	Prion disease / CJD
Chromosome 21	Schizophrenia, Bipolar affective disorder, Alzheimer's (APP), Down syndrome (trisomy 21), Progressive myoclonic epilepsy
Chromosome 22	Schizophrenia, Bipolar affective disorder, Hoarding, DiGeorge/velocardiofacial syndrome (22q11)

NOTE Chromosome 21 is the great multi-tasker: it carries the amyloid precursor protein (APP) gene (Alzheimer's), is trisomic in Down syndrome, and is implicated in schizophrenia and bipolar disorder - which is why almost all people with Down syndrome develop Alzheimer pathology.

NOTE Imprinting on chromosome 15 gives two contrasting syndromes: paternal deletion to Prader-Willi, maternal deletion to Angelman - the classic example of genomic imprinting in psychiatry.

By Disorder (Reverse Lookup)

Disorder	Associated Chromosome(s)
Schizophrenia	1, 6, 7, 8, 13, 21, 22

Disorder	Associated Chromosome(s)
Bipolar affective disorder	1, 8, 13, 18, 21, 22 (and chr 3)
Anxiety	7, 13
Alzheimer's disease	1, 14, 19, 21
Hoarding	4, 5, 17, 22
Autism	2, 4, 7, 13, 15, 16, 17, 19
Mood disorders	4, 12, 18 (and chr 3)
OCD	2, 9
Specific reading disorder (dyslexia)	1, 3, 6, 11, 15
CADASIL	Short arm of chromosome 19 (NOTCH3)
Alcoholism	4
ADHD	Genes on 5, 6, 11 implicated
Primary enuresis	12q, 13q, 13-14q, 22q11

NOTE Schizophrenia and bipolar disorder share a strikingly overlapping set of susceptibility loci (chromosomes 1, 8, 13, 21, 22), supporting a partly shared genetic architecture across the two psychoses.

NOTE The three Alzheimer's genes map to three chromosomes: APP on 21, presenilin-1 on 14, and ApoE on 19 - with chromosome 1 (presenilin-2) completing the familial set.

ANTIDOTES & REVERSAL AGENTS (COMPREHENSIVE)

Antidotes and reversal agents for drug overdoses, poisonings, and psychiatric emergencies - capturing the full source set with additions and doses. Confirm all doses against current local protocols before use.

Antidotes by Toxin / Emergency

Toxin / Condition	Antidote
Anticholinergic toxicity	Physostigmine (reversible cholinesterase inhibitor) - adult 1-2 mg slow IV; paed 0.02 mg/kg
Hypertensive crisis (e.g. MAOI)	Phentolamine (alpha-adrenergic blocker)

Toxin / Condition	Antidote
Benzodiazepine / Z-drug overdose	Flumazenil (also zolpidem, eszopiclone)
Paracetamol (acetaminophen) poisoning	Acetylcysteine (N-acetylcysteine)
Organophosphate / carbamate / muscarinic mushroom	Atropine - adult 1-3 mg IV bolus, repeat; paed 0.05-0.1 mg/kg
Opioid overdose	Naloxone (also clonidine, tizanidine) - 0.4-10 mg IV every 15-45 min or infusion
Most oral ingestions	Activated charcoal (NOT for hydrocarbons, alcohols, metals, corrosives, foreign objects) - adult 50 g; paed 1 g/kg
Serotonin syndrome	Cyproheptadine (5-HT ₂ antagonist) - 12 mg then 8 mg every 6 h (max 32 mg/day)
Neuroleptic malignant syndrome	Dantrolene sodium 1-2.5 mg/kg IV (max 10 mg/kg); also bromocriptine
Acute dystonic reaction	Benztropine (or procyclidine) 1-2 mg IV/IM; also IM diphenhydramine
Methanol / ethylene glycol	Ethanol 95% (or fomepizole) - competes for alcohol dehydrogenase
Beta-blocker / calcium-channel blocker	Glucagon - load 5-10 mg IV then 2.5-5 mg/h
Heavy metals (lead, mercury, arsenic, copper)	D-penicillamine (also for gold, bismuth, etc.)
Wernicke-Korsakoff / ethylene glycol	Thiamine - 500 mg IV every 8 h (Wernicke); 100 mg/day (ethylene glycol)
Iron overdose	Desferrioxamine (chelator)
Warfarin / coumarin	Vitamin K (phytomenadione) +/- prothrombin complex
Digoxin toxicity	Digoxin-specific antibody (Fab) fragments

Toxin / Condition	Antidote
Cyanide	Hydroxocobalamin / sodium thiosulfate / dicobalt edetate

NOTE Three psychiatric-emergency antidotes recur: flumazenil (benzodiazepine overdose), cyproheptadine (serotonin syndrome), and dantrolene (neuroleptic malignant syndrome).

NOTE Physostigmine reverses central anticholinergic toxicity (it crosses the blood-brain barrier, unlike neostigmine), but carries cholinergic risks - cautious slow IV administration is essential.

BIMODAL AGES OF ONSET (COMPREHENSIVE)

Disorders with a characteristic bimodal (two-peak) age of onset - capturing the full source set with additions. A neat, frequently tested epidemiological pattern.

Bimodal Onset Patterns

Disorder	Two Peaks
Specific phobia	Childhood 5-9 yr (natural/animal types); mid-20s (situational type)
Female schizophrenia	Late 20s and again early 50s
Dysthymia	Early 20s (late adolescence) and late (30-50 yr)
Panic disorder	Early 15-24 yr and later 45-54 yr
Trichotillomania	Childhood-onset type and a chronic form in mid-adolescence
Situational phobia	One peak in childhood, another in the mid-twenties
Mania in old age	Bimodal peaks at ages 37 and 73
OCD	Peaks at 12-14 and 20-22 yr (onset declines after 35)
Agoraphobia	First peak 15-35 yr, second peak 45-54 yr
Completed suicide	Raised in both younger (with comorbidity) and older age groups

NOTE Panic disorder and agoraphobia share near-identical bimodal peaks (~15-25 and 45-54 yr); female schizophrenia peaks in the late 20s and again in the early 50s (the late peak linked to oestrogen withdrawal).

NOTE Late-life mania has an unusual within-old-age bimodality, with peaks reported at ages 37 and 73.

TYPICAL AGE OF ONSET (COMPREHENSIVE)

Typical ages of onset across the full range of psychiatric disorders and developmental milestones - capturing the full source set, grouped by life stage, with additions. A core epidemiology reference.

Infancy & Early Childhood

Disorder	Age of Onset
Rett syndrome	Onset 7-24 months
Stereotypic movement (head banging)	5-12 months
Rumination disorder	3-12 months
Pica	2-3 years
Childhood disintegrative disorder	Normal to 2-3 yr, then regression at 3-4 yr (before age 10)
Stammering / stuttering	2-7 yr (peak ~5 yr); 80-90% by age 6
ADHD	Commonly 3-7 yr (symptoms before age 12)
ODD	As early as 3 yr, typically by 8 yr (earlier than CD)
Selective mutism	3-6 yr (when starting nursery/school)
Tics	Prepubertal 4-6 yr, peak severity 10-12 yr
Tourette's	Mean 7 yr (motor tics 7 yr, vocal tics ~11 yr)
Specific phobia	Median 7-11 yr (situational types later, ~20 yr)
School refusal	5-7 yr (esp. 14 yr); mean 10.3 yr; transitions ~10-13 yr
Autism	Before age 3 (developmental delays often earlier)
Separation anxiety disorder	Mean 7.5 yr (normal separation anxiety peaks 9-18 months)

NOTE Onset-before thresholds anchor the neurodevelopmental disorders: ADHD before 12, childhood-onset conduct disorder before 10, autism before 3, and intellectual disability before 18.

Adolescence & Early Adulthood

Disorder	Age of Onset
Anorexia nervosa	16-17 yr (peak 15-19)
Bulimia nervosa	~18 yr (slightly older than anorexia)
Social phobia	After puberty, first onset 11-15 yr (~15 yr)
Body dysmorphic disorder	12-13 yr; two-thirds before age 18
OCD	Mean ~20 yr (men 13-15, women 20-24); a quarter by age 14
Schizophrenia	Men early 20s; women late 20s & early 50s
Bipolar affective disorder	Most common 15-19 (mean 19), ~6 yr before unipolar
Hoarding disorder	Symptoms begin 11-15 yr, gradually worsen
Excoriation / trichotillomania	Around puberty
Conduct disorder	Before age 10 or in adolescence
Borderline personality disorder	Adolescence & early 20s
Narcolepsy	15-25 yr
Alcohol abuse / dependence	Abuse ~17 yr, dependence ~22 yr

NOTE OCD shows a sex difference in onset: males earlier (13-15 yr) than females (20-24 yr), with a quarter of all cases beginning by age 14.

Adulthood

Disorder	Age of Onset
Depressive disorder	~27 yr (18-29 yr ~3x rate of 60 yr)
GAD	~30 yr (mean usually 20s)
Panic disorder	22-25 yr (bimodal 15-25 & 45-54)
PTSD	Any age; average early 20s
Cyclothymia / dysthymia	Late adolescence-20s; late 30-50 yr
Somatization disorder	Before 25 yr in 90% (Briquet's: before 30)

Disorder	Age of Onset
Somatic symptom disorder	Usually before age 30
Hypochondriasis	3rd-4th decade (equal M:F)
Depersonalization	15-30 yr (rare in late life)
Conversion disorder	Late childhood to early adulthood
Factitious disorder	Early adulthood, often after hospitalisation
Delusional disorder	Mean ~42 yr
Late-onset mania	Mean ~55 yr
Dhat syndrome	Early twenties (~50% unmarried)
Chronic fatigue syndrome	29-35 yr
Binge eating disorder	~40 yr (25% are men)

NOTE Delusional disorder (mean ~42 yr) and late-onset mania (mean ~55 yr) are the classic later-onset functional disorders, contrasting with the early-20s onset of schizophrenia and bipolar disorder.

Late Life & Perinatal

Disorder	Age of Onset
Huntington's disease	35-45 yr (childhood onset 10-20% of cases)
GPI (neurosyphilis)	5-25 yr after primary infection
Normal pressure hydrocephalus	Usually over age 60
Familial fatal insomnia	20-40 yr (slow progression); some cite 45-50
Alzheimer's disease	Usually >65 yr (up to 5% early-onset)
Fahr's disease	20-40 yr (schizophreniform/catatonic); 40-60 yr (dementia/choreoathetosis)
REM sleep behaviour disorder	Usually after age 40
Postpartum depression	Within 6 months (peak 3-4 weeks); 10-15%
Postpartum psychosis	First 2 weeks after delivery; 1-2/1000

Disorder	Age of Onset
Postnatal blues	2-3 days after birth, lasts days (up to a week)

NOTE Perinatal timing is precise: baby blues at 2-3 days (peak, resolves within ~1 week), postpartum psychosis within the first 2 weeks, and postpartum depression within 6 months (peak 3-4 weeks).

Developmental Milestones

Milestone	Age
Social referencing (read others' faces)	8-10 months
Recognise self in a mirror	~18 months
Intelligible speech	Fully intelligible by age 4; all speech sounds mastered by 8
ADHD remission	Usual remission between ages 12 and 20
Munchausen by proxy (victim age)	Usually under 4 yr (mean ~4; 75% under 6)

NOTE Two milestone facts are key: self-recognition in a mirror at ~18 months, and social referencing (reading others' facial expressions) at 8-10 months.

NEONATAL & FETAL DRUG EFFECTS (COMPREHENSIVE)

Effects on the fetus and newborn of maternal substance use and psychotropic medication - withdrawal syndromes, malformations, and neonatal complications. Capturing the full source set with additions; always weigh against the risks of untreated maternal illness.

Substances of Misuse

Substance	Neonatal / Fetal Effects
Opioids	Neonatal abstinence syndrome 24-48 h after birth (may delay 3-4 days; methadone 48-72 h, up to 3 weeks); high-pitched cry, hyperirritability, GI dysfunction, respiratory distress, yawning/sneezing/mottling/fever, exaggerated reflexes, loose stools; milder with buprenorphine

Substance	Neonatal / Fetal Effects
Alcohol	Fetal alcohol syndrome; withdrawal within 3-12 h - hyperactivity, irritability, poor sucking, tremors, seizures, poor sleep, hyperphagia, diaphoresis
Cocaine ('crack baby')	Small for gestational age, microcephaly; ~2x low birth weight (mean ~275 g lower)
Amphetamines / cocaine	Increased prematurity & intrauterine growth restriction; neonatal withdrawal unclear
Cannabis (marijuana)	Mild attentional problems & impulsivity; mild opiate-like withdrawal with fine tremors, hyperacusis, prominent Moro reflex (rarely needs treatment)
Volatile substances	Excessive high-pitched crying, sleeplessness, hyperreflexia, tremor, hypotonia, poor feeding
Nicotine (prenatal smoking)	Offspring ADHD, conduct disorder, antisocial behaviour; mild withdrawal (fine tremors, tone variation, poor self-regulation)
Barbiturates	Irritability, severe tremors, hyperacusis, excessive crying, vasomotor instability, diarrhoea, increased tone, hyperphagia, vomiting, disturbed sleep

NOTE Withdrawal timing differs by drug: alcohol within 3-12 h, opioids at 24-48 h (methadone later, up to 3 weeks) - a useful clue to the offending substance in a jittery neonate.

Psychotropic Medications

Medication	Neonatal / Fetal Effects
SSRIs (third trimester)	Neonatal adaptation syndrome (~25%): irritability, jitteriness, poor tone, weak cry, respiratory distress, hypoglycaemia, seizures; persistent pulmonary hypertension (PPHN ~2.5x); paroxetine worst, sertraline less
TCAs (third trimester)	Neonatal withdrawal: agitation, irritability, seizures, respiratory distress, endocrine/metabolic disturbance; anticholinergic TCAs - fetal tachyarrhythmia, urinary retention, intestinal obstruction
Doxepin (breastfeeding)	Only TCA NOT considered safe - poor sucking/swallowing, hypotonia, drowsiness, vomiting reported

Medication	Neonatal / Fetal Effects
Venlafaxine	Cardiac defects; small for gestational age
Bupropion	Increased risk of childhood ADHD
Lithium	'Floppy baby' syndrome (cyanosis, hypotonia), Ebstein's anomaly (~1:1000, 20-40x), neonatal goitre, cardiac arrhythmia, hypoglycaemia, nephrogenic DI, low Apgar; stop 1-2 days before delivery
Benzodiazepines	First-trimester oral clefts; pyloric stenosis, alimentary atresia; third-trimester 'floppy baby' syndrome (hypotonia, lethargy); clonazepam - persistent apnoea
Valproate	Neural tube defects, low verbal IQ (42% <80, 22% <70), 30-40% developmental delay/special education, autism risk; ASD, hepatotoxicity, hypoglycaemia; risk rises above 1 g/day
Carbamazepine	Neural tube defects, craniofacial defects (11%), fingernail hypoplasia (26%), developmental delay (20%); folic acid antagonist (category D); breast milk - cholestatic hepatitis, poor feeding
Phenytoin	Fetal hydantoin syndrome - facial clefting, vitamin K & D deficiency, heart/limb defects, neurological defects
Topiramate	Orofacial clefts
Antipsychotics	Risperidone - small for gestational age, tremor, hyperreflexia, restlessness, irritability, impaired feeding
Zolpidem	Pre-term delivery, low birth weight, increased caesarean
Anorexia (maternal)	Low birth weight, microcephaly, low Apgar; neonatal hypoglycaemia

NOTE 'Floppy baby syndrome' (hypotonia, lethargy, poor feeding) is shared by third-trimester lithium and benzodiazepine exposure; lithium additionally risks Ebstein's anomaly, so it is stopped 1-2 days before delivery.

NOTE Valproate is the most neurodevelopmentally toxic anticonvulsant in pregnancy - up to 40% developmental delay and markedly lowered verbal IQ - making it the agent to avoid in women of childbearing potential.

BEST PREDICTORS (COMPREHENSIVE)

The single best predictor or strongest risk factor for key psychiatric outcomes - relapse, prognosis, treatment response, and recidivism. Capturing the full source set with additions; a key single-best-answer format.

Best Predictor by Outcome

Outcome	Best Predictor / Strongest Factor
Suicide (strongest)	Previous deliberate self-harm / prior suicide attempt
Autism spectrum disorder	Genetic loading (strongest identified risk factor)
Schizophrenia - developing it (prodrome)	Genetic risk (family history)
Schizophrenia relapse (strongest)	Non-compliance with treatment
Schizophrenia - good prognosis	Good initial response to treatment; course in first 2 yr predicts later course
Schizophrenia - long-term functional outcome	Cognitive deficits
Schizophrenia - poor response	Stressful life events, high expressed emotion, non-compliance
Duration of untreated psychosis	Insidious mode of onset (+ negative symptoms, premorbid dysfunction)
Primary nocturnal enuresis	Family history of enuresis (70% have affected parent/sibling)
Future PTSD	Peritraumatic dissociation & perceived lack of social support (also emotional numbing)
Methadone maintenance effectiveness	Total daily dose
Brief psychodynamic psychotherapy outcome	Motivation for change
Ego strength for psychodynamic therapy	Quality of relationships

Outcome	Best Predictor / Strongest Factor
Psychoanalysis outcome (best)	Therapeutic alliance
Relapse to drinking (alcohol dependence)	Difficulty falling asleep (most replicated subjective marker)
Long-term drinking outcome (Project MATCH)	Readiness-to-change & self-efficacy
Sexual functioning after TBI	Depression (most sensitive predictor)
Reactive attachment disorder - outcome	Providing an emotionally available attachment figure
Future insomnia	Previous insomnia
Criminality at 17 (behavioural problems at 8)	Inadequate parenting
Violence in mental illness (mediator)	Substance abuse
Suicide in epilepsy	Comorbid psychiatric disorder
Incomplete recovery between bipolar I episodes	Mood-incongruent psychotic symptoms
Poor response to behavioural therapy in panic/agoraphobia	Catastrophic agoraphobic cognitions
Sexual offence recidivism (strongest)	Sexual interest in children (phallometric); deviant sexual preference
ACT service outcome	Case load (UK700 study)

NOTE Two unmissable 'strongest predictor' answers: previous deliberate self-harm for suicide, and non-compliance with treatment for schizophrenia relapse.

NOTE Therapy-outcome predictors cluster around the relationship and readiness: therapeutic alliance (psychoanalysis), motivation for change (brief psychodynamic), and readiness-to-change/self-efficacy (drinking outcome in Project MATCH).

BEST CHOICE IN SPECIAL CONDITIONS (COMPREHENSIVE)

The recommended drug of choice in special clinical contexts - HIV, multiple sclerosis, perinatal, and specific syndromes - largely reflecting Maudsley Guidelines. Capturing the full source set with additions; confirm against the current edition.

HIV (Maudsley Guidelines)

Problem	Best Choice
HIV - psychosis	Atypicals; risperidone most studied
HIV - delirium	Atypicals + low-dose short-acting benzodiazepine
HIV - depression	SSRIs, especially citalopram
HIV - bipolar	Valproate, lamotrigine, gabapentin (lithium tolerated poorly; avoid carbamazepine)
HIV dementia	Antiretroviral therapy (zidovudine best evidence)

NOTE In HIV, citalopram is the antidepressant of choice and risperidone the most-studied antipsychotic; HIV dementia may stabilise on antiretrovirals, with zidovudine having the best evidence.

Multiple Sclerosis & Stroke

Problem	Best Choice
MS - depression	SSRIs (first-line, Maudsley)
MS - pathological laughing/crying	Amitriptyline or fluoxetine
MS - emotional lability	Amitriptyline and SSRIs
MS - mania	Mood stabilisers (preferred over lithium due to tolerance)
Post-stroke pathological laughing/crying	Citalopram or sertraline

NOTE Pathological laughing/crying is treated with amitriptyline or fluoxetine in MS, but citalopram or sertraline after stroke - a context-dependent distinction worth memorising.

Other Conditions

Condition	Best Choice
Body dysmorphic disorder	Fluoxetine (best evidence; delusional respond as well as non-delusional)

Condition	Best Choice
PMS / PMDD (severe)	SSRIs - fluoxetine most effective (also sertraline); response 60-90% vs 30-40% placebo
SIADH (drug-induced)	Fluid restriction; demeclocycline in some cases
Pregnancy (antidepressant - Maudsley)	Fluoxetine, amitriptyline, imipramine
Breastfeeding (antidepressant - Maudsley)	Paroxetine and sertraline

NOTE Fluoxetine is the best-evidenced agent for body dysmorphic disorder - and notably, delusional BDD responds as well as non-delusional BDD, arguing against routine antipsychotic augmentation.

DEMENTIAS - KEYWORDS & FEATURES (COMPREHENSIVE)

A comprehensive feature-based reference to the dementias - degenerative, vascular, prion, and secondary - with the discriminating 'keywords' for each. Capturing the full source set with additions; one of the most important old-age psychiatry topics.

Neurodegenerative Dementias

Dementia	Key Features
Alzheimer's disease	Insidious onset, gradual progression, early loss of insight (anosognosia). Stage 1: anomia, defective visuospatial/calculation, indifferent personality. Stage 2: fluent aphasia, worsening memory/visuospatial/personality, EEG slowing, temporoparietal atrophy. Stage 3: severe intellectual & speech impairment (palilalia, echolalia, mutism), sphincter disturbance, diffuse atrophy. Medial temporal atrophy most consistent; neuritic plaques, NFTs, granulovacuolar degeneration, Hirano bodies

Dementia	Key Features
Frontotemporal dementia (Pick's)	Younger onset (<65), strong familial/genetic (40% familial, AD; tau on chr 17). Early personality/conduct breakdown, disinhibition/apathy, carbohydrate craving, loss of insight; memory & visuospatial spared early. Non-fluent aphasia. Knife-blade gyri, Pick bodies (tau & ubiquitin+), balloon cells; serotonergic (NOT cholinergic) deficit. Recent > remote memory preserved
Semantic-variant FTD	Fluent, empty speech; semantic errors (a rabbit called a cat); single-word repetition preserved
Behavioural-variant FTD	Apathy or disinhibition, loss of social graces, stimulus boundedness, sweet craving; insight impaired; cognition relatively preserved early (~70% of FTD presentations)
Huntington's disease	Early executive dysfunction (processing speed, organisation, planning) rather than memory; lack of initiative (commonest behavioural change), poor judgement, blunted affect; abnormal movements, age 40-50, anxious/depressed; box-car ventricles, caudate shrinkage
Dementia with Lewy bodies	Core: fluctuating cognition (attention/alertness), recurrent well-formed visual hallucinations, spontaneous parkinsonism, REM sleep behaviour disorder. '1-year rule'; neuroleptic sensitivity (life-threatening); falls/syncope, autonomic dysfunction, anosmia/constipation years before; relative sparing of medial temporal lobe; only dementia with inclusion bodies; low DaT uptake
Parkinson's disease dementia	Cognitive impairment a LATE symptom, ≥ 1 yr after motor signs (mean 10, up to 20 yr); slower progression than DLB; psychosis as late/severe marker
Progressive supranuclear palsy	Prominent parkinsonism, early gait disturbance/falls (retropulsion), vertical gaze palsy, pseudobulbar palsy, axial dystonia; onset 6th decade; tau-positive NFTs

Dementia	Key Features
Corticobasal degeneration	Asymmetric akinesia/rigidity, limb dystonia, apraxia, myoclonus, dysphagia, alien limb; tau-positive glial inclusions; clonazepam for myoclonus

NOTE The DLB core tetrad (fluctuating cognition, visual hallucinations, spontaneous parkinsonism, REM sleep behaviour disorder) plus the '1-year rule' and dangerous neuroleptic sensitivity distinguishes it from Parkinson's disease dementia, where cognition declines a year or more AFTER motor signs.

NOTE Frontotemporal dementia is younger-onset, strongly familial (tau gene, chromosome 17), serotonergic (NOT cholinergic - so cholinesterase inhibitors don't help), and presents with personality/conduct change and knife-blade gyri with Pick bodies.

Vascular Dementias

Dementia	Key Features
Vascular dementia (general)	Stepwise (decremental) deterioration, focal neurological signs, comorbid hypertension/PVD/atherosclerosis; lacunar lesions; insight preserved until late; pseudobulbar palsy, dysarthria, dysphagia common
Post-stroke dementia	Emotional & personality changes first, then memory/intellect; independent predictor of mortality
Binswanger's disease	Subcortical vascular encephalopathy; enlarged ventricles, deep white-matter infarction; reduced processing speed (most characteristic), frontal executive dysfunction; severe hypertension; pseudobulbar/pyramidal/parkinsonian features, fluctuating cognition, incontinence
CADASIL	Notch 3 mutation, chromosome 19; autosomal dominant; recurrent subcortical strokes (80%), cognitive decline (50%), mood changes (30%), epilepsy (10%); migraine with aura ~40%; only monogenic ischaemic stroke syndrome
Multiple lacunar state	Small subcortical infarcts; dysarthria, incontinence, explosive laughing (frontal disturbance)
Leukoaraiosis	Patchy diffuse white-matter change; no sulcal/ventricular enlargement; found in $\geq 3/4$ of presumed multi-infarct dementia

NOTE Stepwise deterioration with focal signs and preserved insight points to vascular dementia; Binswanger's adds reduced processing speed and deep white-matter disease, while CADASIL is the monogenic (Notch 3, chromosome 19) cause with migraine-with-aura in ~40%.

Prion, Surgical & Secondary Dementias

Dementia	Key Features
Creutzfeldt-Jakob disease	Rapid cognitive decline + ≥ 2 of: myoclonus (>90%), visual/cerebellar signs (ataxia, nystagmus), pyramidal/extrapyramidal signs, akinetic mutism. Periodic sharp-wave (triphasic) EEG, CSF 14-3-3 protein, putamen/caudate MRI lesions; spongiform change, neuronal loss, astrocytosis, prion amyloid plaques
Variant CJD	Young men in 20s; early anxiety & depression, then personality change, then dementia; ataxia & myoclonus prominent; pulvinar sign on MRI (sensitivity 78%, specificity 100%); tonsillar biopsy most specific; course 1-2 yr to death
Normal pressure hydrocephalus	'3 Ws' - Wobbly (gait), Wet (urinary incontinence), Wacky (cognition); gait first/most prominent; enlarged ventricles (esp. 3rd) out of proportion to atrophy, ballooned frontal horns; normal CSF pressure; onset 60s-70s; subcortical pattern
HIV dementia	Subcortical pattern: impaired executive function, slowed processing, attentional/learning difficulty; recognition better than recall (subcortical); PML on MRI
Korsakoff's (alcohol) dementia	Prominent anterograde amnesia (severe difficulty learning new information, rapid forgetting) with confabulation
General paresis of the insane (GPI)	Depression, frontal personality change (disinhibition, overactivity - mistaken for hypomania), grandiose delusions in only 10%; slurred speech, lip/tongue tremor, Argyll Robertson pupils (50%), spastic paralysis later
Dementia due to TBI	History of head injury with loss of consciousness, post-traumatic amnesia, confusion/disorientation, or neuroimaging/neurological evidence of injury

NOTE CJD pairs rapidly progressive dementia with myoclonus, triphasic EEG complexes, and CSF 14-3-3 protein; variant CJD differs - young men, early psychiatric onset, and the MRI pulvinar sign (specificity ~100%).

NOTE NPH's '3 Ws' (Wobbly, Wet, Wacky) is a potentially reversible dementia: the gait disturbance comes first, is most prominent, and is the most likely to improve after shunting.

CYTOCHROME P450 (CYP) INTERACTIONS (COMPREHENSIVE)

Cytochrome P450 substrates, inducers, and inhibitors relevant to psychiatry - the basis of psychotropic drug interactions. Capturing the full source set with additions; a key psychopharmacology topic.

Substrates

Enzyme / Drug	Substrates
CYP1A2 substrates	Clozapine, olanzapine, duloxetine, agomelatine, theophylline, caffeine, imipramine
CYP2D6 substrates	Typical antipsychotics, risperidone, aripiprazole, TCAs, fluoxetine, paroxetine, venlafaxine, mirtazapine, donepezil, galantamine, atomoxetine, codeine
CYP3A4 substrates	Clozapine, quetiapine, ziprasidone, reboxetine, carbamazepine, donepezil, pimozide, methadone, benzodiazepines (midazolam)
CYP2C19 substrates	SSRIs (most, for elimination - citalopram, escitalopram, sertraline), diazepam, TCAs, clopidogrel
Donepezil	Metabolised by CYP2D6 and CYP3A4
Clozapine	Metabolised by CYP1A2, CYP3A4, CYP2D6
Reboxetine	Mostly CYP3A4
NOT primarily via CYP2D6	Bupropion, moclobemide, mirtazapine, reboxetine, sertraline, citalopram

NOTE Clozapine sits at the centre of CYP interactions: metabolised by 1A2, 3A4, and 2D6. Smoking and caffeine INDUCE 1A2 (lowering levels - so smoking cessation can cause toxicity), while ciprofloxacin and fluvoxamine INHIBIT 1A2 (raising levels).

Inducers (lower drug levels)

Inducer	Effect
CYP1A2 inducers	Cigarette smoking, caffeine - reduce clozapine/olanzapine levels (smoking cessation raises levels)

Inducer	Effect
CYP3A4 inducers	Rifampicin, carbamazepine, phenytoin, St John's Wort - reduce clozapine/substrate levels
Cannabis	Inhibits CYP3A4 and CYP1A2
Broad inducers	Barbiturates, rifampicin, carbamazepine, phenytoin, chronic alcohol

NOTE Enzyme inducers (rifampicin, carbamazepine, phenytoin, smoking, St John's Wort) **REDUCE** substrate levels - a frequent cause of antipsychotic treatment failure.

Inhibitors (raise drug levels)

Inhibitor	Effect
CYP1A2 inhibitors	Ciprofloxacin, fluvoxamine - raise clozapine & theophylline levels
CYP2D6 inhibitors	Fluoxetine, paroxetine, bupropion, duloxetine - raise TCA/risperidone levels
CYP3A4 inhibitors	Erythromycin, clarithromycin, ketoconazole, grapefruit juice, ritonavir - raise clozapine/substrate levels
Fluvoxamine + theophylline	Fluvoxamine (potent CYP1A2 inhibitor) raises theophylline levels
Fluoxetine + clozapine	Fluoxetine (potent CYP2D6 inhibitor) raises clozapine - increased seizure risk
Valproate (inhibitor)	Inhibits glucuronidation - raises lamotrigine > 2-fold (rash/SJS risk)

NOTE Fluoxetine and paroxetine are potent CYP2D6 inhibitors - combining fluoxetine with clozapine raises clozapine levels and seizure risk; valproate inhibits glucuronidation, doubling lamotrigine levels (rash/SJS risk).

TWIN CONCORDANCE RATES (COMPREHENSIVE)

Monozygotic (MZ) versus dizygotic (DZ) twin concordance rates across psychiatric disorders - the classic evidence for genetic contribution. Capturing the full source set with additions; figures vary between studies.

MZ vs DZ Concordance

Disorder	MZ vs DZ Concordance
Autism	MZ > 90% vs DZ low (~0-10%)
Bipolar / mood disorders	MZ 60-70% vs DZ ~20%
Schizophrenia	MZ ~46-50% vs DZ ~14% (for comparison)
Anorexia nervosa	MZ ~55% vs DZ ~0-5%
Bulimia nervosa	MZ ~23-35% vs DZ ~9-30%
ADHD	MZ ~79% vs DZ ~32%
OCD	MZ ~57-87% vs DZ ~22-50%
Unipolar depression	MZ ~46% vs DZ ~20%
Borderline personality disorder	MZ ~35% vs DZ ~10% (MZ:DZ ratio up to 5:1, like schizophrenia)
Antisocial - adult criminality	MZ 52% vs DZ 22% (genetic contribution)
Antisocial - juvenile delinquency	MZ 87% vs DZ 72% (familial, NOT mainly genetic)
Premenstrual syndrome	MZ 0.55 vs DZ 0.28
Female orgasmic disorder	Genetics account for ~30% of variability in orgasm frequency
Panic disorder	Highest heritability among anxiety disorders (~7-fold familial risk)

NOTE Autism has the highest twin concordance in psychiatry (MZ > 90%), underscoring its strong genetic basis; bipolar and mood disorders run MZ 60-70% vs DZ ~20%.

NOTE The antisocial data dissociate genetic from familial effects: adult criminality shows a clear MZ > DZ gap (52% vs 22%, genetic), but juvenile delinquency is high in BOTH (87% vs 72%, familial/environmental rather than genetic).

BLACK BOX WARNINGS (COMPREHENSIVE)

FDA/MHRA black-box and serious safety warnings for psychotropic drugs - capturing the full source set with additions. Essential prescribing-safety knowledge; confirm against current product information.

Black Box & Serious Warnings

Drug	Warning
All antidepressants	FDA 2004 black-box: increased suicidal thoughts & behaviour in children, adolescents & young adults (<25) Venlafaxine dose-related hypertension
Aripiprazole	Carries antidepressant suicide warning (adjunct in MDD); NOT approved for paediatric depression
All antipsychotics	Increased all-cause mortality in elderly (>65) with dementia-related psychosis (esp. cardiovascular events & infections)
Clozapine	Agranulocytosis; myocarditis; seizures; orthostatic hypotension; increased mortality in elderly dementia psychosis
Nefazodone	Idiopathic hepatic failure (life-threatening)
Valproate (Depakine)	Hepatic toxicity (possibly fatal), haemorrhagic pancreatitis, teratogenicity
Carbamazepine	Agranulocytosis or aplastic anaemia; serious dermatologic reactions (SJS/TEN, esp. HLA-B*1502)
Atomoxetine	Severe hepatic disorders (rare, <1/50,000); suicidal ideation in children/adolescents
Droperidol	QT prolongation & torsades de pointes
Tetrabenazine	Worsening depression & suicidality (depletes monoamines); only FDA-approved drug for Huntington's chorea
Pimozide	QT prolongation; ventricular arrhythmias
Stimulants (methylphenidate, amphetamines)	High potential for abuse & dependence; sudden cardiac death with structural cardiac abnormality

NOTE The two most-tested black-box warnings: all antidepressants for increased suicidality in under-25s (FDA 2004), and all antipsychotics for increased mortality in elderly dementia-related psychosis.

NOTE Tetrabenazine - the only FDA-approved drug for Huntington's chorea - carries a depression/suicidality warning because it depletes monoamines, a neat pharmacology-meets-safety point.

COMORBIDITY (COMPREHENSIVE)

Characteristic psychiatric comorbidities across disorders - the conditions most commonly co-occurring with each. Capturing the full source set with additions; a key clinical and exam topic.

Comorbidity by Disorder

Disorder	Common Comorbidities
Anxiety disorders	Most common comorbidity is another anxiety disorder
OCD	~ $\frac{2}{3}$ have another lifetime disorder; commonest is major depression ($\frac{1}{3}$ current, $\frac{2}{3}$ lifetime)
Body dysmorphic disorder	Major depression (lifetime ~75%) commonest; OCD ~ $\frac{1}{3}$; social anxiety ~40%; substance use
Schizophrenia	~25% have comorbid depression
Post-stroke	Depression in up to 50-60%; onset 3-24 months
Hypochondriasis	88% have another disorder: GAD 71%, dysthymia 45%, depression 43%, somatization 21%, panic 17%; 3x more likely to have a PD
Epilepsy	Depression 30-50%, panic disorder 20%, psychosis 3-7%
Somatic symptom disorder	Depression, anxiety (GAD/panic/social phobia), adjustment, psychotic, histrionic & dissocial PD, substance misuse
Paraphilic disorders	Mood, anxiety, substance use (esp. alcohol), personality disorders
Down syndrome	OCD (2%, need for order), depression, autism, bipolar, psychosis, sleep apnoea
Conversion disorder	Association with antisocial personality disorder
Prader-Willi	Obsessive-compulsive disorder
Bipolar children	ADHD ~70%, ODD 40%, anxiety 30%, substance misuse 40%, Tourette's 8%, bulimia 3%
Secondary enuresis	Most evidence for ADHD comorbidity

Disorder	Common Comorbidities
Homicide-suicide (intimate/family)	Depression commonest associated diagnosis
Self-harm presenting to hospital	>90% have a mental disorder, commonest depression
Separation anxiety disorder	School refusal in ~75% of SAD; SAD in up to 80% of school refusal
Angelman syndrome	Epilepsy in 90%; severe/profound learning disability

NOTE Major depression is the single commonest comorbidity across OCD (lifetime ~ $\frac{2}{3}$), body dysmorphic disorder (~75%), and self-harm presentations (>90% have a disorder, usually depression).

NOTE Hypochondriasis is highly comorbid - 88% have another disorder, led by GAD (71%) - and patients are three times more likely than the general population to have a personality disorder.

COURSE OF DISORDERS (COMPREHENSIVE)

The typical clinical course of psychiatric disorders - chronic, episodic, relapsing, or fluctuating - capturing the full source set with additions. Useful for prognosis and exam recognition.

Typical Course by Disorder

Disorder	Typical Course
Excoriation disorder	Chronic, with waxing and waning
Trichotillomania	Chronic with fluctuation
Factitious disorder	Intermittent episodes throughout life
Somatic symptom disorder	Chronic and fluctuating
Hypochondriacal disorder	Usually episodic
Conversion disorder	Individual symptoms short (most resolve by discharge); 20-25% relapse within 1 year
PANDAS	Chronic with periods of exacerbation
Delirium	Rapid onset (hours-days), brief (days-weeks), fluctuating, worse at night (sundowning)
Panic disorder	Chronic and relapsing

Disorder	Typical Course
Schizophrenia	Course in first 2 years predicts subsequent course; ~2/3 chronic/relapsing
Bipolar disorder	Recurrent; episodes become more frequent & inter-episode interval shortens with age
GAD	Chronic; ~half who recover later relapse
Major depression (untreated episode)	Typically 6-13 months; ~6 months if treated

NOTE Delirium's course is the diagnostic signature: rapid onset (hours-days), brief duration (days-weeks), and marked fluctuation with nocturnal worsening (sundowning) - distinguishing it from the insidious, stable course of dementia.

NOTE Conversion symptoms are typically short-lived (most resolve by hospital discharge), but 20-25% relapse within a year - a prognostic figure worth recalling.

CORE FEATURES (COMPREHENSIVE)

The defining core features of key psychiatric and neuropsychiatric disorders - the essential diagnostic kernel of each. Capturing the full source set with additions.

Core Features by Disorder

Disorder	Core Feature(s)
Dementia with Lewy bodies	Cognitive fluctuations, visual hallucinations, REM sleep behaviour disorder, parkinsonism
Delirium	Altered consciousness (usually decreased), altered attention, other cognitive dysfunction (disorientation, impaired memory), sleep-wake disturbance, rapid fluctuating course
Restless legs syndrome	Distressing, irresistible urge to move legs with paraesthesia, worse at rest/evening, relieved by movement
Chronic fatigue syndrome	Fatigue (the core symptom), post-exertional malaise
Neurasthenia	Fatigue (mental or physical)

Disorder	Core Feature(s)
Borderline (EUPD)	Frantic efforts to avoid real or imagined abandonment
Creutzfeldt-Jakob disease	Spongiform change, neuronal loss, astrocytosis, amyloid (prion) plaque formation
Charles Bonnet syndrome	Recurrent, well-formed, vivid, elaborate, often stereotyped visual hallucinations in a partially-sighted person with intact insight
PTSD	Re-experiencing (flashbacks/nightmares), avoidance, hyperarousal, negative alterations in cognition/mood
Mania	Elevated/irritable mood, increased energy/activity (DSM-5 gateway), grandiosity, reduced need for sleep
Anorexia nervosa	Restriction → low weight, intense fear of weight gain, body-image disturbance

NOTE The DLB core-feature tetrad (fluctuating cognition, visual hallucinations, REM sleep behaviour disorder, parkinsonism) needs two of four for a probable diagnosis - one of the most-tested feature sets in old-age psychiatry.

NOTE Charles Bonnet syndrome's core is complex, well-formed visual hallucinations with INTACT insight in a partially-sighted (usually elderly) person - the preserved insight separates it from psychosis.

CONFIRMING / DIAGNOSTIC TESTS (COMPREHENSIVE)

The investigation that confirms (or best supports) the diagnosis for key conditions - capturing the full source set with additions. A key single-best-answer reference.

Confirmatory Test by Condition

Condition	Confirming / Diagnostic Test
Huntington's disease	Genetic (CAG repeat) testing confirms diagnosis
Wernicke's encephalopathy	MRI (sensitivity ~53% but specificity ~93% - confirms when positive, can't exclude)
Creutzfeldt-Jakob disease	EEG periodic sharp-wave complexes; CSF 14-3-3 protein; MRI (cortical ribboning, pulvinar sign in vCJD); definitive = brain biopsy/autopsy

Condition	Confirming / Diagnostic Test
Variant CJD	Tonsillar biopsy (most specific); MRI pulvinar sign (specificity ~100%)
Alzheimer's disease	Clinical; supportive - MRI medial temporal atrophy, CSF amyloid/tau, amyloid PET; HMPAO-SPECT differentiates AD/VaD/FTD
Narcolepsy	Multiple Sleep Latency Test (mean latency <8 min, ≥ 2 SOREMPs); low CSF hypocretin/orexin
Wilson's disease	Low serum caeruloplasmin, raised urinary copper, Kayser-Fleischer rings (slit-lamp)
Acute intermittent porphyria	Raised urinary porphobilinogen & ALA (urine darkens on standing)
Neurosyphilis (GPI)	CSF VDRL/TPHA; serum treponemal tests
Phenylketonuria	Guthrie test (neonatal heel-prick); raised phenylalanine
Delirium	Confusion Assessment Method (CAM); EEG diffuse slowing; identify underlying cause
Anti-NMDA receptor encephalitis	Anti-NMDA receptor antibodies (serum/CSF); screen for ovarian teratoma

NOTE Two clean 'confirmatory test' answers: genetic CAG-repeat testing for Huntington's, and MRI for Wernicke's (low sensitivity ~53% but high specificity ~93% - it confirms when positive but cannot exclude).

NOTE For variant CJD, tonsillar biopsy is the most specific test and the MRI pulvinar sign approaches 100% specificity - distinct from sporadic CJD, where periodic EEG complexes and CSF 14-3-3 protein dominate.

CONTRAINDICATIONS (COMPREHENSIVE)

Key contraindications and cautions for psychotropic drugs and treatments - capturing the full source set with extensive additions. Essential prescribing-safety knowledge; confirm against current BNF/product information.

Contraindications by Drug

Drug / Treatment	Contraindications & Cautions
Haloperidol / typical antipsychotics	Parkinson's disease, Lewy body dementia (worsen parkinsonism, severe EPSE), prolonged QT, phaeochromocytoma
Disulfiram	Impulsivity, psychosis, suicidality, severe hepatic dysfunction, peripheral neuropathy, cardiac disease, pregnancy; recent alcohol/metronidazole
MAOIs	Tyramine-rich foods, sympathomimetics, SSRIs/clomipramine/pethidine (serotonin syndrome), phaeochromocytoma; cerebrovascular disease
Lithium	Significant renal impairment, untreated hypothyroidism, cardiac disease, dehydration/sodium depletion, Addison's; caution in pregnancy (Ebstein's)
Clozapine	Previous agranulocytosis/neutropenia, severe cardiac disease (myocarditis), uncontrolled epilepsy, paralytic ileus, bone-marrow disorders
Bupropion	Seizure disorder, eating disorders (bulimia/anorexia), abrupt alcohol/benzodiazepine withdrawal, MAOI use
TCAs	Recent MI, arrhythmias/heart block, severe liver disease, mania, narrow-angle glaucoma, prostatic hypertrophy
Stimulants (methylphenidate)	Structural cardiac abnormality/arrhythmia, severe hypertension, hyperthyroidism, psychosis, phaeochromocytoma, glaucoma
Carbamazepine	AV conduction abnormality, bone-marrow depression, acute porphyria, MAOI use; HLA-B*1502 (SJS risk)
Sodium valproate	Women of childbearing potential (without pregnancy-prevention programme), hepatic dysfunction, urea-cycle disorders, mitochondrial disease, porphyria
Benzodiazepines	Severe respiratory insufficiency, sleep apnoea, severe hepatic impairment, myasthenia gravis; caution with substance dependence

Drug / Treatment	Contraindications & Cautions
ECT (relative)	Raised intracranial pressure (absolute), recent MI/stroke, unstable aneurysm, phaeochromocytoma, severe anaesthetic risk

NOTE Typical antipsychotics (haloperidol) are contraindicated in Parkinson's disease and Lewy body dementia, where they worsen parkinsonism and can trigger life-threatening neuroleptic sensitivity - use quetiapine or clozapine instead.

NOTE Bupropion's seizure risk makes it contraindicated in eating disorders and in abrupt alcohol/benzodiazepine withdrawal - a frequently tested safety pairing.

DRUG-INDUCED DISORDERS (COMPREHENSIVE)

Drugs and substances that can induce psychiatric syndromes - the iatrogenic and substance-related differential that must be excluded before diagnosing a primary disorder. Capturing the full source set with additions.

Drug-Induced Syndromes

Syndrome	Causative Drugs / Substances
Depression	Beta-blockers, clonidine, methyldopa, reserpine, corticosteroids, levodopa, sedative-hypnotics, anticonvulsants, oral contraceptives, interferon, isotretinoin, stimulant withdrawal, alcohol
Mania / bipolar	Antidepressants, sympathomimetics, dopamine agonists, corticosteroids, levodopa, bronchodilators, cocaine, amphetamines
Psychosis	Corticosteroids, dopaminergic/antiparkinsonian agents, anticholinergics, antihistamines, methylphenidate, chemotherapy; alcohol, cocaine, LSD, ecstasy, cannabis, PCP, sedative withdrawal
Anxiety / panic	Caffeine, stimulants, decongestants (ephedrine, albuterol), corticosteroids, thyroxine (over-replacement), SSRIs (initiation), theophylline, anticholinergic toxicity, baclofen, narcotic/benzodiazepine withdrawal

Syndrome	Causative Drugs / Substances
Cognitive impairment / delirium	Anticholinergics, antihistamines, sedative-hypnotics, narcotics, corticosteroids, antiparkinsonian agents, anticonvulsants, lithium, cimetidine, digoxin, indometacin, disopyramide
OCD-like symptoms	Amphetamines, cocaine, levodopa, dopamine agonists, heavy metals, atypical antipsychotics (clozapine)
Sexual dysfunction	SSRIs, antipsychotics (hyperprolactinaemia), beta-blockers, thiazides, TCAs, MAOIs
Hyperprolactinaemia	Risperidone, amisulpride, sulpiride, haloperidol, metoclopramide
Weight gain	Olanzapine, clozapine, mirtazapine, valproate, lithium, TCAs
Serotonin syndrome	SSRIs + MAOIs/triptans/tramadol/linezolid/St John's Wort; SSRI overdose

NOTE Corticosteroids are the great mimics - they can induce depression, mania, psychosis, or anxiety depending on dose and host, and feature in nearly every drug-induced differential.

NOTE Anticholinergics, antihistamines, sedatives, opioids, lithium, digoxin, and cimetidine are the classic precipitants of drug-induced delirium, especially in the elderly - always review the medication chart first.

PREGNANCY RISK CATEGORIES (COMPREHENSIVE)

FDA pregnancy risk categories (A-X) for psychotropic drugs - capturing the full source set with additions. Note: the FDA replaced letter categories with the PLLR narrative system in 2015, but letters remain widely used in exams. Confirm current guidance before prescribing.

Psychotropics by Pregnancy Category

Category	Drugs
Category A (safest)	No psychotropics; folic acid, levothyroxine
Category B	Buspirone, diphenhydramine, clozapine, bupropion, maprotiline, zolpidem (some list C)

Category	Drugs
Category C	Most antipsychotics, most SSRIs (fluoxetine, sertraline, citalopram), TCAs, venlafaxine, zolpidem, gabapentin
Category D	Paroxetine (cardiac defects), lithium (Ebstein's), most benzodiazepines, carbamazepine, valproate, lamotrigine; most mood stabilisers
Category X (contraindicated)	Some hypnotics - temazepam, triazolam, flurazepam; (thalidomide, isotretinoin)
Benzodiazepines (overview)	Most category D; temazepam/triazolam/flurazepam are X; diphenhydramine B

NOTE Among antidepressants, paroxetine is the category D outlier (first-trimester cardiac defects), whereas most other SSRIs are category C - a key reason paroxetine is avoided in pregnancy.

NOTE Most benzodiazepines are category D, but three hypnotics are category X (temazepam, triazolam, flurazepam) - the most restrictive class within the benzodiazepines.

BREASTFEEDING & PSYCHOTROPICS (COMPREHENSIVE)

Safety of psychotropic drugs in breastfeeding - preferred agents and those to avoid. Capturing the full source set with additions; confirm against current Maudsley/specialist guidance.

Psychotropics in Breastfeeding

Drug	Breastfeeding Guidance
Sertraline	First-line antidepressant in breastfeeding (USA); low milk transfer
Paroxetine	Also recommended (Maudsley) - low infant exposure
Fluoxetine	Detected in milk & infant plasma (long half-life); rare irritability/cyanosis/somnolence at higher doses; no developmental effect - less preferred
TCAs (except doxepin)	Considered safe if infant full-term, healthy & monitored

Drug	Breastfeeding Guidance
Doxepin	AVOID - poor sucking, hypotonia, drowsiness, vomiting reported
Antipsychotics	Olanzapine preferred; avoid clozapine (agranulocytosis risk) & high-dose
Lithium	AVOID - lethargy, poor tone, ECG changes; significant milk transfer
Zolpidem	Relatively safe - hypnotic of choice in breastfeeding
Bupirone, zaleplon, zopiclone	Excreted in milk - should be avoided (zopiclone up to 50% maternal level)
Methadone	Compatible - keep dose as low as possible, monitor infant for sedation; encourage breastfeeding
Benzodiazepines	Short-acting low-dose (lorazepam) preferred; avoid long-acting (accumulation)
Valproate / carbamazepine	Generally compatible; monitor infant (carbamazepine - hepatic, poor feeding)

NOTE Sertraline (and paroxetine) are the antidepressants of choice in breastfeeding due to low milk transfer; fluoxetine is less preferred because its long half-life leads to detectable infant plasma levels.

NOTE Two clear avoids in breastfeeding: lithium (infant lethargy, ECG changes) and doxepin (the one TCA that is unsafe) - while zolpidem is the preferred hypnotic.

ETHICAL DECLARATIONS (COMPREHENSIVE)

The major ethical declarations and codes relevant to medicine and psychiatry - their purpose and origin. Capturing the full source set with additions; a recurring medical-ethics exam topic.

Declarations & Codes

Declaration	Purpose / Content
Declaration of Geneva	Revision of the Hippocratic Oath; adopted by WMA 1948 after Nazi-era crimes; physician's pledge of dedication to humanity

Declaration	Purpose / Content
Declaration of Helsinki	Ethical principles for medical research involving human subjects (WMA 1964); cornerstone of research ethics
Declaration of Tokyo	Doctors must refuse to participate in, condone, or permit torture or cruel/degrading treatment of prisoners/detainees
Declaration of Malta	Guidance for doctors treating hunger strikers
Declaration of Lisbon	International statement of the rights of patients
Declaration of Ottawa	Principles necessary for optimal child health
Declaration of Hawaii	First ethical position statement of the psychiatric profession (Blomquist; WPA, 1977); guidance for psychiatrists in conflicts of loyalty & decision-making
Declaration of Madrid	WPA ethical standards for psychiatric practice (1996); superseded/expanded Hawaii
Nuremberg Code (1947)	Foundational research-ethics code; voluntary informed consent is essential
Declaration of Sydney	Statement on death and the determination of death

NOTE Match the declaration to its theme: Geneva (modern Hippocratic Oath), Helsinki (research ethics), Tokyo (against torture), Malta (hunger strikers), Lisbon (patients' rights), and Hawaii/Madrid (psychiatric ethics).

NOTE The Declaration of Hawaii (WPA, 1977) was the **FIRST** ethical position statement of the psychiatric profession - later expanded by the Declaration of Madrid (1996).

DSM HISTORY & DSM-5 CHANGES (COMPREHENSIVE)

The evolution of the DSM and the key changes introduced in DSM-5 - capturing the full source set with additions. A key classification-history topic.

DSM Editions & Key Changes

Edition / Change	Detail
DSM-I (1952)	First edition; psychoanalytic 'reactions'; influenced by Adolf Meyer

Edition / Change	Detail
DSM-II (1968)	Retained psychoanalytic framework; homosexuality listed (removed 1973)
DSM-III (1980)	First to provide explicit inclusion/exclusion criteria, extensive descriptive text, multiaxial system; ELIMINATED the term 'neurosis'; PTSD introduced; atheoretical (Feighner/RDC roots)
DSM-III-R (1987)	Revision; child PTSD addressed; refinement of criteria
DSM-IV (1994) / IV-TR (2000)	Empirically based; added clinical-significance criterion; multiaxial retained
DSM-5 (2013)	First to emphasise clinical utility, require empirical basis for changes, and set eligibility criteria limiting commercial influence; dropped multiaxial system & Roman numerals
DSM-5 - autism	Asperger's & autistic disorder COMBINED into autism spectrum disorder
DSM-5 - substance	Substance abuse & dependence COMBINED into substance use disorder
DSM-5 - panic/agoraphobia	Panic disorder and agoraphobia UNLINKED (separate diagnoses)
DSM-5 - somatoform	Several somatoform disorders grouped into somatic symptom disorder
DSM-5 - neurocognitive	Mild neurocognitive disorder added; 'dementia' → major neurocognitive disorder
DSM-5 - schizophrenia	Removed special status of bizarre delusions & Schneiderian first-rank symptoms; DELETED the five subtypes
DSM-5 - bereavement	Bereavement exclusion ELIMINATED from major depression (with clarifying text on grief)
DSM-5 - eating	Binge-eating disorder added in new 'Feeding and Eating Disorders' chapter

Edition / Change	Detail
DSM-5 - gambling	Gambling disorder MOVED to 'Substance-Related and Addictive Disorders' (first behavioural addiction)

NOTE DSM-III (1980) was the watershed: it introduced explicit operational criteria, a multiaxial system, and PTSD, and ELIMINATED the term 'neurosis' - shifting psychiatry toward a descriptive, atheoretical model.

NOTE Signature DSM-5 changes: Asperger's merged into autism spectrum disorder, the schizophrenia subtypes were deleted, the bereavement exclusion was removed from depression, and gambling disorder became the first recognised behavioural addiction.

CULTURE-BOUND SYNDROMES (COMPREHENSIVE)

Culture-bound (cultural concepts of distress) syndromes - their region and characteristic features. The original source covered the 'running' syndromes; this expands to the full classic set, a key cross-cultural psychiatry topic.

Culture-Bound Syndromes

Syndrome	Region & Features
Amok	Malaysia/SE Asia; sudden unprovoked rampage of violence after a period of brooding, then amnesia & exhaustion ('running' syndrome)
Latah	Malaysia/Indonesia; exaggerated startle with echolalia, echopraxia, automatic obedience (esp. middle-aged women)
Koro	SE Asia/China; sudden fear that the penis (or vulva/nipples) is retracting into the body and may cause death
Dhat	Indian subcontinent; anxiety & hypochondriacal concern about semen loss in urine, weakness, fatigue
Windigo / Wendigo	Native American (Algonquian); delusion of transforming into a cannibalistic monster with craving for human flesh
Piblokto (Arctic hysteria)	Inuit/Eskimo (Greenland); abrupt dissociative excitement, tearing off clothes, running on ice, then amnesia
Grisi siknis	Miskito of Nicaragua/Honduras; agitation, running about, trance, amnesia ('running' syndrome)

Syndrome	Region & Features
Brain fag	West Africa; difficulty concentrating/remembering in students; head/neck discomfort
Susto (espanto)	Latin America; 'soul loss' after a frightening event - insomnia, anorexia, anxiety, withdrawal
Ataque de nervios	Latino/Caribbean; uncontrollable shouting/crying, trembling, aggression, dissociation after a stressor
Taijin kyofusho	Japan; fear of offending/embarrassing others through one's body, odour, or gaze (cf. social phobia)
Hikikomori	Japan; extreme social withdrawal/isolation lasting ≥ 6 months
Zar	North Africa/Middle East; spirit possession with dissociative episodes, shouting, laughing, head-banging
Bouffee delirante	West Africa/Haiti; sudden agitated outburst with confusion & psychomotor excitement (acute transient psychosis)

NOTE The 'running' syndromes share agitation, running about, trance, and amnesia: amok and latah (western Pacific rim), grisi siknis (Miskito of Central America), and piblokto/Arctic hysteria (Inuit) - the cluster highlighted in the source.

NOTE Two are commonly confused: koro (fear of genital retraction causing death, SE Asia) versus dhat (anxiety over semen loss, Indian subcontinent) - both reflect culturally-shaped somatic anxiety about sexual organs.

ENANTIOMERS & ACTIVE FORMS (COMPREHENSIVE)

Chiral psychotropic drugs and their active enantiomers or metabolites - capturing the source (eszopiclone) with extensive additions. A neat pharmacology topic.

Enantiomers & Active Forms

Drug	Enantiomer / Active Form
Escitalopram	S-(+)-enantiomer of racemic citalopram; the active enantiomer (R-form may antagonise effect); fewer CYP interactions

Drug	Enantiomer / Active Form
Eszopiclone (Lunesta)	S-(+)-enantiomer of racemic zopiclone; unpleasant (metallic) taste common; category C; not structurally related to zaleplon
Dexmethylphenidate	D-(threo)-enantiomer of racemic methylphenidate; the pharmacologically active form
Dextroamphetamine	D-enantiomer of amphetamine; more potent CNS stimulant than the L-form
Levomilnacipran	More active enantiomer of milnacipran (SNRI); greater noradrenergic potency
Armodafinil	R-enantiomer of racemic modafinil; longer-lasting wakefulness-promoting effect
Levomethadone	L-(R)-enantiomer of methadone; the active opioid analgesic enantiomer
Desvenlafaxine	Major active metabolite (O-desmethylvenlafaxine) of venlafaxine, not strictly an enantiomer
S-ketamine (esketamine)	S-enantiomer of ketamine; ~2-4x more potent NMDA antagonist; intranasal for treatment-resistant depression

NOTE The 'es-' and 'dex-/lev-' prefixes flag single-enantiomer drugs: escitalopram is the active S-enantiomer of citalopram, eszopiclone the S-enantiomer of zopiclone, and dexmethylphenidate the active D-enantiomer of methylphenidate.

NOTE Esketamine (S-ketamine) is a 2-4x more potent NMDA antagonist than racemic ketamine and is licensed intranasally for treatment-resistant depression.

BEST EVIDENCE-BASED TREATMENTS (COMPREHENSIVE)

The treatment with the best evidence base for specific clinical problems - capturing the full source set with additions. A key single-best-answer reference.

Best-Evidence Treatment by Problem

Problem	Best-Evidence Treatment
Residual positive symptoms on clozapine	Amisulpride (best evidence for augmentation)

Problem	Best-Evidence Treatment
Negative symptoms of schizophrenia	Amisulpride (best examined antipsychotic)
Social phobia (pharmacological)	SSRIs (best evidence base, most commonly used)
Parkinson's disease dementia	Rivastigmine (best evidence base)
Insomnia (non-pharmacological)	Stimulus control therapy (best-evidenced); CBT-I overall
Functional recovery in chronic psychosis	Supported employment - Individual Placement and Support (IPS)
Body dysmorphic disorder	Fluoxetine (best evidence)
HIV dementia	Antiretroviral therapy - zidovudine best evidence
Treatment-resistant schizophrenia	Clozapine (only agent with robust evidence)
Treatment-resistant depression (augmentation)	Lithium (most evidence); also atypical antipsychotics
Bulimia nervosa (pharmacological)	Fluoxetine 60 mg (best evidence)
Reducing suicide in schizophrenia	Clozapine (only drug with this indication)

NOTE Amisulpride recurs twice: it has the best evidence for negative symptoms of schizophrenia and for augmenting clozapine against residual positive symptoms.

NOTE Clozapine is unique in having the best evidence for BOTH treatment-resistant schizophrenia and reducing suicide risk in schizophrenia - the only antipsychotic with the latter indication.

BEST DIAGNOSTIC TESTS (COMPREHENSIVE)

The best (gold-standard or most specific) diagnostic test for key conditions - capturing the full source set with additions. Complements the confirming-tests compilation.

Best Diagnostic Test by Condition

Condition	Best Diagnostic Test
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Condition	Best Diagnostic Test
Phaeochromocytoma	Plasma free metanephrines (most specific/sensitive); 24-h urinary metanephrines/catecholamines
Autism (direct symptom assessment)	Autism Diagnostic Observation Schedule (ADOS) - gold standard, ~40-min semi-structured
Autism (parental information, research)	Autism Diagnostic Interview-Revised (ADI-R)
Huntington's disease	Genetic CAG-repeat testing (confirmatory)
Wernicke's encephalopathy	MRI (specificity ~93%, sensitivity ~53%)
Wilson's disease	Serum caeruloplasmin (low), 24-h urinary copper (high), slit-lamp (KF rings)
Narcolepsy	Multiple Sleep Latency Test (MSLT) + CSF hypocretin/orexin
Cushing's syndrome	Overnight/low-dose dexamethasone suppression test; late-night salivary cortisol; 24-h urinary free cortisol
Delirium	Confusion Assessment Method (CAM); EEG diffuse slowing
Catatonia	Lorazepam challenge test (>80% respond rapidly)
Organic vs psychogenic stupor	Amobarbital (Amytal) interview - organic worsens, psychogenic improves
Anti-NMDA receptor encephalitis	Anti-NMDA antibodies (CSF/serum); screen for teratoma

NOTE Two gold standards from the source: plasma free metanephrines for phaeochromocytoma (most specific), and the ADOS for direct symptom assessment in autism (with ADI-R for parental information in research).

NOTE Two bedside challenge tests double as diagnosis and treatment: the lorazepam challenge in catatonia (>80% respond) and the amobarbital interview, where organic stupor worsens but psychogenic stupor improves.

KEY DOSES & DOSING REGIMENS (COMPREHENSIVE)

Important doses, titration schedules, and challenge-test protocols in psychiatry - capturing the full source set with additions. Doses are for revision only; always confirm against the current BNF before prescribing.

Doses & Regimens

Drug / Test	Dose / Regimen
Acamprosate	>=60 kg: 666 mg three times daily; <60 kg: 666/333/333 mg; start soon after detox; benefit may persist 1-2 yr
Naloxone (opioid overdose)	0.4-2 mg IV/IM/SC, repeat every 2-3 min up to max 10 mg; short-acting (re-narcotisation in 20-60 min) - monitor; call emergency services
Lorazepam challenge (catatonia)	1 mg IV, repeat 1 mg after 2-5 min if no response; >80% respond; leads to lorazepam trial then ECT
Thiamine (Wernicke's - treatment)	500 mg IV three times daily for 3 days (250 mg three times daily for 3-5 days if at-risk); IM 200 mg for 5 days outpatient; give BEFORE carbohydrate
Lamotrigine added to valproate	Halve doses: 25 mg alternate days x2 wk, 25 mg/day x2 wk, 50 mg/day x1 wk, then 100 mg/day; max 100 mg/day (unless on hormonal contraceptive)
Naltrexone (opioid relapse prevention)	Start 25 mg, increase to 50 mg daily; can give 3 days/week (100 mg Mon & Wed, 150 mg Fri) to aid compliance
Bromocriptine (NMS)	2.5 mg orally three times daily, up to 45 mg/day; max 40 mg/day; taper over 1 week after symptoms abate
Dantrolene (NMS)	1-2.5 mg/kg IV every 4-6 h; oral 1-2 mg/kg four times daily x10 days; max 10 mg/kg/day
Amantadine (NMS)	100-200 mg orally twice daily; max 200 mg every 12 h
Physostigmine (anticholinergic toxicity)	0.5-2.0 mg IV; rapidly metabolised - repeat every ~2 h
Atomoxetine	Start 0.3 mg/kg/day; titrate over 1-3 wk to 1.2 mg/kg/day; max 1.4 mg/kg/day or 100 mg (whichever less)

Drug / Test	Dose / Regimen
Clonidine (ADHD/tics)	Start 0.05 mg at bedtime; titrate to 0.15-0.30 mg/day in 3-4 divided doses
Lisdexamfetamine (BED)	Start 30 mg/day, increase to 50-70 mg/day
Ketamine (depression studies)	0.5 mg/kg IV
Dexamethasone suppression test	1 mg oral at 11 PM; plasma cortisol at 8 AM & 4 PM; >5 mug/dL = non-suppression (abnormal)
Pentobarbital challenge (barbiturate detox)	200 mg orally, monitor; estimate 24-h requirement, convert to phenobarbital (pentobarbital 100 mg = phenobarbital 30 mg)
Varenicline	12-week course; additional 12 weeks for those who quit by end of first course

NOTE Thiamine in suspected Wernicke's is given parenterally and BEFORE any carbohydrate (glucose can precipitate encephalopathy) - oral thiamine is unreliable because absorption caps at ~4.5 mg.

NOTE Lamotrigine doses are HALVED when added to valproate (which inhibits its glucuronidation) to reduce the risk of serious rash/Stevens-Johnson syndrome - one of the most-tested dosing adjustments.

DIAGNOSTIC CRITERIA & THRESHOLDS (COMPREHENSIVE)

Core DSM-5 diagnostic criteria, symptom counts, and duration thresholds for major disorders, with mnemonics. The source file was blank; this builds the essential criteria set as a key reference.

Key Diagnostic Criteria

Disorder	Criteria / Thresholds
Major depressive episode	>=5/9 symptoms for >=2 weeks, including depressed mood or anhedonia (SIGECAPS): Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicidality
Manic episode	Elevated/irritable mood + increased energy >=1 week (or any duration if hospitalised); >=3 (4 if irritable) of DIGFAST: Distractibility, Indiscretion, Grandiosity, Flight of ideas, Activity, Sleep decreased, Talkativeness

Disorder	Criteria / Thresholds
Hypomanic episode	Same symptoms, ≥ 4 days, no marked impairment/psychosis/hospitalisation
Generalised anxiety disorder	Excessive worry most days ≥ 6 months + $\geq 3/6$ symptoms (restlessness, fatigue, concentration, irritability, muscle tension, sleep)
Panic disorder	Recurrent unexpected attacks + ≥ 1 month of worry/avoidance; $\geq 4/13$ symptoms peak within 10 min
PTSD	Trauma exposure + intrusion, avoidance, negative cognition/mood, hyperarousal > 1 month
Schizophrenia	≥ 2 of (delusions, hallucinations, disorganised speech, disorganised/catatonic behaviour, negative symptoms) for ≥ 1 month, ≥ 1 must be a positive symptom; ≥ 6 months total disturbance
Schizophreniform	Schizophrenia symptoms 1-6 months
Brief psychotic disorder	1 day to 1 month, full return to function
Schizoaffective	≥ 2 weeks of psychosis without mood episode, but mood episodes present majority of illness
Anorexia nervosa	Restriction $\rightarrow$ significantly low weight, intense fear of weight gain, body-image disturbance (DSM-5 dropped amenorrhoea)
Bulimia nervosa	Binge + compensatory behaviour ≥ 1 x/week for 3 months; self-evaluation unduly influenced by shape/weight
Binge-eating disorder	Binges ≥ 1 x/week for 3 months, no regular compensatory behaviour
OCD	Obsessions and/or compulsions, time-consuming (> 1 h/day) or distressing/impairing
ADHD	≥ 6 (≥ 5 if ≥ 17 yr) inattentive and/or hyperactive-impulsive symptoms, ≥ 6 months, onset before age 12, ≥ 2 settings

Disorder	Criteria / Thresholds
Delirium	Disturbed attention/awareness, acute onset & fluctuation, additional cognitive disturbance, due to a medical cause
Antisocial PD	Pattern of disregard for others' rights since age 15; ≥ 18 yr; evidence of conduct disorder before 15

NOTE Duration thresholds distinguish the psychotic disorders: brief psychotic disorder (<1 month), schizophreniform (1-6 months), and schizophrenia (≥ 6 months) - a frequently tested time-line.

NOTE Mnemonics speed recall: SIGECAPS (≥ 5 for depression) and DIGFAST ($\geq 3-4$ for mania) capture the symptom counts that define the two core mood episodes.

FDA APPROVALS (COMPREHENSIVE)

FDA-approved indications for psychotropic drugs and neurostimulation - capturing the full source set with additions. Approvals differ between countries and change over time; confirm current labelling.

Mood, Anxiety & Related

Indication	FDA-Approved Agents
OCD	Fluoxetine, fluvoxamine, paroxetine, sertraline, clomipramine, escitalopram
Bulimia nervosa	Fluoxetine
Binge-eating disorder	Lisdexamfetamine (Vyvanse)
PTSD	Paroxetine, sertraline
GAD	Paroxetine, escitalopram, duloxetine, venlafaxine
Panic disorder	Alprazolam, clonazepam, fluoxetine, paroxetine, sertraline, venlafaxine
Social anxiety disorder	Fluvoxamine, paroxetine, sertraline, venlafaxine
PMDD	Fluoxetine, paroxetine, sertraline
Nocturnal enuresis	Amitriptyline, imipramine, nortriptyline

Indication	FDA-Approved Agents
Bipolar depression	Fluoxetine+olanzapine, lurasidone, quetiapine, cariprazine
Bipolar maintenance	Lamotrigine, lithium, olanzapine, aripiprazole, quetiapine, risperidone, ziprasidone
Acute mania	Lithium, valproate, carbamazepine + most SGAs (aripiprazole, asenapine, cariprazine, olanzapine, quetiapine, risperidone, ziprasidone)
Postpartum depression	Brexanolone (Zulesso); zuranolone (newer)

NOTE Fluoxetine holds several solo approvals - bulimia nervosa, PMDD, and (combined with olanzapine) bipolar/treatment-resistant depression - making it one of the most broadly licensed SSRIs.

Psychosis, Neuro & Other

Indication	FDA-Approved Agents
Schizophrenia	Most antipsychotics (aripiprazole, olanzapine, risperidone, quetiapine, etc.); clozapine for resistant & suicide reduction
ADHD	Amphetamine, methylphenidate, atomoxetine, clonidine, guanfacine
Autism-related irritability	Risperidone, aripiprazole
Tourette's disorder	Aripiprazole, haloperidol, pimozide
Alzheimer's disease	Donepezil, galantamine, rivastigmine, memantine
Parkinson's disease psychosis	Pimavanserin
Tardive dyskinesia	Deutetrabenazine (Austedo), valbenazine (Ingrezza) - VMAT2 inhibitors
Huntington's chorea	Tetrabenazine; deutetrabenazine
Opioid maintenance / relapse	Buprenorphine, methadone; naltrexone (relapse prevention)
Alcohol	Acamprosate, disulfiram, naltrexone; chlordiazepoxide (withdrawal)

Indication	FDA-Approved Agents
Nicotine dependence	Varenicline, bupropion
Narcolepsy / sleepiness	Modafinil, armodafinil, methylphenidate, amphetamine, pitolisant, solriamfetol; sodium oxybate (cataplexy)
Insomnia	Doxepin, temazepam, triazolam, zolpidem, zaleplon
Restless legs syndrome	Pramipexole, rotigotine, ropinirole, gabapentin
Hypoactive sexual desire (premenopausal women)	Flibanserin; bremelanotide
Neurostimulation	ECT; rTMS (depression); VNS (resistant depression/epilepsy); DBS (Parkinson's)

NOTE Two VMAT2 inhibitors (deutetrabenazine, valbenazine) are FDA-approved for tardive dyskinesia, while pimavanserin is uniquely approved for Parkinson's disease psychosis.

FIRST-LINE TREATMENTS (COMPREHENSIVE)

First-line treatments across psychiatric disorders and special populations, largely reflecting NICE guidance - capturing the full source set with additions. Always individualise and confirm against current guidelines.

First-Line Treatment by Condition

Condition	First-Line Treatment
PTSD	Trauma-focused CBT/EMDR (psychological); SSRIs first-line pharmacological
Akathisia	Beta-blockers (propranolol) first-line
Post-stroke depression	SSRIs first-line
Psychotic depression	Antidepressant + antipsychotic, or ECT
Bipolar in children (acute mania)	Atypical antipsychotics (olanzapine, risperidone) preferred, then valproate/lithium (NICE)
ADHD - preschool (<5 yr)	Parent-training/education; drugs NOT first-line

Condition	First-Line Treatment
ADHD - child moderate (5-18 yr)	Group parent-training first; medication after psychological therapies
ADHD - child severe	Methylphenidate (drug) first-line
ADHD - adults	Methylphenidate first-line (atomoxetine if misuse/diversion concern)
Childhood insomnia	Melatonin first-line
BPSD (dementia)	Non-drug measures (e.g. music therapy) first-line
Depression in children/adolescents	Psychological therapy first; fluoxetine if these fail
Mild OCD in young people	Guided self-help, then CBT with ERP
Moderate-severe OCD (young)	CBT with ERP, then combine with SSRI/clomipramine
Bulimia nervosa	Psychological interventions (guided self-help / CBT-ED) first-line
Anorexia nervosa	CBT-ED, MANTRA, or SSCM; nutritional rehabilitation & weight restoration
Lewy body dementia	Cholinesterase inhibitors (rivastigmine, donepezil) first-line
Late paraphrenia	Risperidone 1-3 mg/day first-line (then olanzapine/quetiapine)
Depression in PLWH (HIV)	SSRIs, esp. citalopram/escitalopram (no CYP2D6/3A4 inhibition)
Psychosis in PLWH	Quetiapine, risperidone, aripiprazole
Bipolar in PLWH	Valproate (lithium/carbamazepine problematic)
Huntington's chorea (no depression)	Tetrabenazine
Huntington's chorea (+ depression/psychosis)	Antipsychotics (risperidone, olanzapine)
Autism	Appropriate educational provision (no curative drug)

NOTE ADHD first-line treatment is age- and severity-dependent: parent-training for preschoolers and moderate cases, but medication (methylphenidate) first-line for severe childhood ADHD and for adults.

NOTE Several first-line answers are NON-pharmacological: beta-blockers may be drug-of-choice for akathisia, but melatonin leads for childhood insomnia, non-drug measures for BPSD, and psychological therapy for paediatric depression and bulimia.

LANDMARK EXPERIMENTS & STUDIES (COMPREHENSIVE)

Classic psychology and research-ethics experiments - their investigators and findings. Capturing the full source list with descriptions added. A key topic for psychology and ethics.

Research-Ethics Landmarks

Study	Description
Tuskegee syphilis study (1932-72)	US PHS observed untreated syphilis in ~400 Black men, denied treatment even after penicillin; led to modern research-ethics reform & informed consent
Willowbrook hepatitis study (1956-70)	Intellectually disabled children deliberately infected with hepatitis to track the disease; landmark unethical study
The Monster Study (1939)	Wendell Johnson induced stuttering/speech problems in orphan children through negative speech therapy
Tearoom Trade study (Humphreys)	Covert observation of male-male sex in public toilets; classic research-ethics (privacy/consent) controversy

NOTE The Tuskegee syphilis study (untreated syphilis in Black men, 1932-72) is the watershed research-ethics scandal that drove the Belmont Report and modern informed-consent requirements.

Social Psychology

Experiment	Finding
Milgram obedience experiments (1963)	Participants administered (fake) escalating shocks on an authority's instruction; ~65% went to maximum - obedience to authority
Stanford Prison Experiment (Zimbardo, 1971)	Students role-played guards/prisoners; rapid conformity to brutal/submissive roles; stopped early

Experiment	Finding
Asch conformity experiments (1950s)	Participants conformed to an obviously wrong majority on a line-judgement task - normative social influence
Bystander effect / Kitty Genovese	Darley & Latane: more bystanders → less likely any individual helps (diffusion of responsibility)
Robbers Cave (Sherif, 1954)	Realistic conflict theory; intergroup hostility reduced by superordinate goals
Bobo doll experiment (Bandura)	Children imitated observed aggression - social learning theory (observational learning)
Cognitive dissonance (Festinger, 1959)	\$1 vs \$20 task; those paid less changed attitudes more to reduce dissonance
Good Samaritan (Darley & Batson)	Seminary students in a hurry helped less - situational over dispositional factors
Schachter-Singer (1962)	Two-factor theory of emotion: physiological arousal + cognitive label
Blue eyes/brown eyes (Jane Elliott)	'A Class Divided' - demonstrated arbitrary discrimination & prejudice in schoolchildren
Robbers' false consensus (Ross)	Tendency to overestimate how much others share our views

NOTE The obedience/conformity trio is essential: Milgram (obedience to authority, ~65% to maximum shock), Zimbardo's Stanford Prison (conformity to roles), and Asch (conformity to a wrong majority).

Learning, Memory & Diagnosis

Experiment	Finding
Rosenhan 'On Being Sane in Insane Places' (1973)	Pseudopatients feigned one symptom, admitted & labelled schizophrenic; critique of validity of psychiatric diagnosis & labelling
Little Albert (Watson & Rayner, 1920)	Classical conditioning of fear of a white rat in an infant; conditioned emotional response (never deconditioned - unethical)

Experiment	Finding
Pavlov's dogs	Classical conditioning - neutral stimulus (bell) paired with food elicits salivation
Learned helplessness (Seligman)	Dogs exposed to inescapable shock later failed to escape; model of depression
Harlow's monkeys	Infant monkeys preferred a cloth 'mother' over a wire one with food - contact comfort & attachment
The Marshmallow Test (Mischel)	Delayed gratification in children predicted later outcomes
Visual cliff (Gibson & Walk)	Depth perception in infants
Fantz's looking chamber	Infant visual preference (prefer faces/patterns) - early perception research
Invisible gorilla (Simons & Chabris)	Inattention blindness - selective attention misses unexpected events
Magical number seven (Miller, 1956)	Short-term memory capacity $\sim 7 \pm 2$ items
Halo effect	A single positive trait biases overall judgement of a person
Hawthorne effect	Behaviour changes simply because of being observed/studied
Car crash / misinformation (Loftus)	Leading-question wording altered eyewitness memory of speed - reconstructive memory
Third Wave (Ron Jones)	Classroom demonstration of how fascism/authoritarian conformity can arise

NOTE Rosenhan's 'On Being Sane in Insane Places' (1973) is the classic critique of psychiatric diagnostic validity and labelling; Little Albert is the classic (unethical) demonstration of conditioned fear.

ICD vs DSM DIFFERENCES (COMPREHENSIVE)

Differences between ICD and DSM classifications across disorders - criteria, durations, and terminology. Capturing the full source set with additions; a key classification topic.

ICD vs DSM by Disorder

Disorder	ICD vs DSM Difference
Adjustment disorder	ICD: within 1 month of stressor; DSM: within 3 months
Acute stress (transient)	ICD: symptoms diminish after 48 h if stress relieved
Encopresis	ICD: ≥ 1 /month for 6 months; DSM: ≥ 1 /month for 3 months (age ≥ 4)
Enuresis	ICD: age > 7 needs 1/month x3mo, age < 7 needs 2/month x3mo; DSM: 2/week for 3 months
Conduct disorder	ICD: ≥ 1 behaviour for ≥ 6 months; DSM: ≥ 3 of 15 behaviours, onset before 13, over 12 months
Conduct subtypes	DSM: childhood-onset (< 10) vs adolescent-onset; ICD: socialised, unsocialised, family-confined, ODD
Bipolar disorder	ICD: needs ≥ 2 mood episodes with recovery between; DSM: a single manic episode suffices
Mixed states	Manic + depressive symptoms daily for ≥ 1 week (DSM-IV) or ≥ 2 weeks (ICD-10)
ADHD / hyperkinetic disorder	ICD-10: one form (needs hyperactivity + inattention + impulsivity); DSM-5: 3 subtypes (inattentive, hyperactive-impulsive, combined)
Attachment disorder	ICD-10: reactive & disinhibited as two types; DSM-IV: inhibited & disinhibited as types of RAD
Hoarding	Not mentioned in ICD-10; a distinct disorder in DSM-5
Munchausen by proxy	ICD: child abuse; DSM: factitious disorder imposed on another
Insomnia	DSM: ≥ 3 nights/week for ≥ 3 months; ICD: nearly every day for ≥ 1 month
Hypersomnolence	DSM: ≥ 3 x/week for ≥ 3 months (main sleep ≥ 7 h); ICD: nearly every day for ≥ 1 month
Erectile dysfunction	ICD: 4 descriptive types (by pattern of erection failure); DSM: lifelong/acquired + situational/generalised

Disorder	ICD vs DSM Difference
Gender identity	ICD-10: under 'disorders of adult personality & behaviour'; DSM-5: gender dysphoria
Paraphilias	ICD-10: disorders of sexual preference; DSM-5: paraphilic disorders
Anorexia nervosa	ICD-10: weight 15% below expected, BMI <17.5; DSM-5 dropped the specific 15% & amenorrhoea criteria
PMDD/PMS	DSM: premenstrual dysphoric disorder; ICD-10: premenstrual tension syndrome
Schizotypal disorder	ICD-10: a disorder (>=2 years; 'quasi-psychotic episodes'); DSM-5: schizotypal personality disorder
Delusional disorder	Bizarre/non-bizarre distinction removed in DSM-5
Dependence	ICD-10: >=3 of 8 features for diagnosis
Tic disorder duration	DSM-IV: >1 yr with no tic-free period >3 months; DSM-5 simplified to >1 yr since onset

NOTE The bipolar threshold differs fundamentally: ICD-10 requires at least two mood episodes, whereas DSM allows the diagnosis after a single manic episode - a frequently tested contrast.

NOTE ADHD splits by system: ICD-10 hyperkinetic disorder requires all of hyperactivity, inattention, and impulsivity, while DSM-5 recognises three subtypes (inattentive, hyperactive-impulsive, combined).

GENES & PSYCHIATRIC DISORDERS (COMPREHENSIVE)

Candidate and causative genes for psychiatric and neurogenetic disorders - capturing the full source set with additions. A key molecular-genetics reference.

Genes by Disorder

Disorder	Gene(s)
Schizophrenia	Dysbindin (DTNBP1, chr 6p), neuregulin-1 (NRG1, chr 8), COMT (chr 22), DISC1, dopamine D2 receptor
Cannabis-induced psychosis	COMT val/val allele (high-risk genotype)
Tardive dyskinesia	Gly/Gly allele of DRD3 (dopamine D3 receptor) gene

Disorder	Gene(s)
Late-onset depression	MTHFR (C677T) polymorphism
Alzheimer's - early onset	Presenilin-1 (PSEN1, chr 14, ~70% early-onset), presenilin-2 (chr 1), APP (chr 21, ~20%)
Alzheimer's - late onset	ApoE epsilon-4 (chr 19) - risk gene
Rett syndrome	MECP2 gene (Xq28) - X-linked dominant
Fragile X	FMR1 gene (X chromosome) - CGG triplet expansion
Lesch-Nyhan syndrome	HPRT gene (X-linked) - hypoxanthine-guanine phosphoribosyltransferase deficiency
Wilson's disease	ATP7B gene (chromosome 13)
CADASIL	Notch3 gene (chromosome 19)
Prion disease / CJD	PRNP (PrP) gene (chromosome 20)
Pick's disease / FTD	Tau (MAPT) gene (chromosome 17q21)
Tuberous sclerosis	TSC1 (hamartin) & TSC2 (tuberin) genes
Autism	NRXN1 (neurexin-1), NLGN3/NLGN4 (neuroligin), SHANK3, FMR1, MECP2
Anorexia nervosa	BDNF gene (chromosome 11) polymorphism
ADHD	DAT1 (dopamine transporter), DRD4 (D4 receptor), SNAP-25; genes 5, 6, 11
Narcolepsy	HLA-DQB1*06:02 association; hypocretin/orexin pathway

NOTE Schizophrenia's classic candidate genes are dysbindin (DTNBP1, chr 6p), neuregulin-1, and COMT (chr 22); the COMT val/val genotype also raises the risk of cannabis-induced psychosis.

NOTE The Alzheimer's gene set maps cleanly: early-onset autosomal-dominant forms involve PSEN1 (chr 14), PSEN2 (chr 1), and APP (chr 21), while ApoE epsilon-4 (chr 19) is the major late-onset risk gene.

HERITABILITY (COMPREHENSIVE)

Heritability estimates across psychiatric disorders and personality disorders - capturing the full source set with additions. Figures are approximate and population-dependent.

Heritability by Disorder

Disorder	Heritability
Bipolar affective disorder	~85% (highest among major psychiatric disorders)
Schizophrenia	~80-85%
Autism	>80%
ADHD	~70-80%
Alzheimer's disease	~75%
Cocaine use disorder	~72%
Schizotypal personality disorder	0.72
Paranoid personality disorder	0.69
Borderline personality disorder	~69%
OCPD	0.78
Agoraphobia	~61%
Dependent personality disorder	0.57
Alcohol dependence	~56%
Schizoid personality disorder	0.55
Pathological gambling	~55%
Anorexia nervosa	~50-60%
Bulimia nervosa	~50%
Conduct disorder	~50%
Orgasmic dysfunction (females)	~45%
Major depression	~40%
Panic disorder	~35-40%
Phobia	~35%
Avoidant personality disorder	0.28
GAD	~28%
OCD	~25-50%

Disorder	Heritability
School refusal	<40%

NOTE The heritability hierarchy peaks with bipolar disorder (~85%), schizophrenia and autism (~80%+), and ADHD (~70-80%) - all substantially more heritable than depression (~40%) or the anxiety disorders.

NOTE Among personality disorders, the Cluster A traits are notably heritable (schizotypal 0.72, paranoid 0.69), as is OCPD (0.78), while avoidant PD is lower (~0.28).

GENETIC CONTRIBUTION (COMPREHENSIVE)

The genetic contribution to substance use and other disorders, and family-recurrence risks - capturing the full source set with additions. Complements the heritability and relatives'-risk compilations.

Genetic Contribution & Recurrence

Disorder	Genetic Contribution
Alcohol use disorder	Genetic ~60% of risk; Native American/Alaskan Native especially at risk
Cannabis use disorder	Genetic 30-80% of risk
Tobacco use disorder	~50% genetic
OCD	~35% of relatives also affected; genetic contribution recognised
ADHD	Genes 5, 6, 11; DAT1 (dopamine transporter), DRD4, SNAP-25
Conduct disorder	Environment more prominent than genes overall; callous-unemotional traits more heritable
Schizophrenia (relatives' risk)	1 parent ~13%, both parents ~46%, MZ co-twin ~48%, sibling ~9%, general population ~1%
Bipolar (relatives' risk)	First-degree relative ~5-10x general population risk

NOTE Substance-use heritability rises with the drug: alcohol ~60%, tobacco ~50%, cannabis 30-80% - with strong gene-environment interplay (availability, peer use, attitudes).

NOTE Conduct disorder is the exception where ENVIRONMENT outweighs genes overall - except for callous-unemotional traits, which carry the highest heritability within the syndrome.

INHERITANCE PATTERNS (COMPREHENSIVE)

Modes of inheritance for psychiatric and neurogenetic disorders - capturing the full source set with additions. A precise, frequently tested genetics topic.

Inheritance Patterns

Disorder	Inheritance Pattern
Rett syndrome	X-linked DOMINANT (lethal in most males)
Fragile X	X-linked (CGG triplet repeat expansion; anticipation)
Lesch-Nyhan	X-linked recessive (HPRT)
Late-onset Alzheimer's	Autosomal dominant with age-dependent expression & low penetrance (apparent sporadic cases)
Early-onset familial Alzheimer's	Autosomal dominant (PSEN1, PSEN2, APP)
CADASIL	Autosomal dominant (Notch3)
Pick's disease / FTD	~50% autosomal dominant (tau gene, chr 17)
Familial fatal insomnia	Autosomal dominant (PRNP)
Huntington's disease	Autosomal dominant (CAG repeat; anticipation, esp. paternal)
Wilson's disease	Autosomal recessive (ATP7B)
Phenylketonuria	Autosomal recessive
Congenital adrenal hyperplasia	Autosomal recessive (21-hydroxylase deficiency in most)
Tuberous sclerosis	Autosomal dominant (TSC1/TSC2)
Neurofibromatosis type 1	Autosomal dominant (chr 17)
Acute intermittent porphyria	Autosomal dominant
Prader-Willi / Angelman	Genomic imprinting (chr 15) - paternal deletion vs maternal deletion

NOTE Three neuropsychiatric dementias are autosomal dominant: Huntington's (CAG repeat, anticipation), familial Alzheimer's, and ~50% of frontotemporal dementia (tau gene); CADASIL and familial fatal insomnia are also dominant.

NOTE Rett syndrome is X-linked DOMINANT (usually lethal in males), distinguishing it from the X-linked recessive Lesch-Nyhan and the triplet-repeat fragile X.

DRUG HALF-LIVES (COMPREHENSIVE)

Elimination half-lives of psychotropic drugs - relevant to dosing, discontinuation, and accumulation. The source file was blank; this builds the essential half-life set as a key reference. Values are approximate.

Half-Lives by Drug

Drug	Half-Life
Fluoxetine	1-4 days (active metabolite norfluoxetine 7-15 days) - longest SSRI; self-tapering
Paroxetine	~21 hours - short; worst discontinuation syndrome
Sertraline	~26 hours
Citalopram / escitalopram	~35 hours / 27-32 hours
Venlafaxine	~5 hours (XR ~15 h) - short; marked discontinuation
Vortioxetine	~66 hours
Diazepam	20-100 hours (active metabolites) - long-acting
Lorazepam / oxazepam / temazepam	10-20 hours - short/intermediate, no active metabolites ('LOT' - safe in liver disease)
Midazolam	~2-3 hours - ultra-short
Chlordiazepoxide	5-30 hours (long-acting metabolites) - alcohol withdrawal
Zolpidem / zaleplon	~2.5 hours / ~1 hour - ultra-short hypnotics
Lithium	18-24 hours (longer in elderly/renal impairment)
Lamotrigine	~25-33 hours (halved by carbamazepine, doubled by valproate)
Valproate	~9-16 hours
Carbamazepine	Initially 25-65 h, falls to ~12-17 h (auto-induction)
Haloperidol	~12-38 hours

Drug	Half-Life
Olanzapine	~30 hours
Quetiapine	~6-7 hours (short)
Aripiprazole	~75 hours (active metabolite ~94 h) - very long
Clozapine	~12 hours
Risperidone	~3 h (active metabolite paliperidone ~24 h)
Methadone	~15-60 hours (long; accumulation risk)
Buprenorphine	~24-42 hours (long)
Naloxone	~60-90 minutes (short - re-narcotisation risk)
Modafinil	~15 hours

NOTE Half-life predicts discontinuation symptoms: fluoxetine's very long half-life (norfluoxetine 7-15 days) makes it self-tapering, whereas short-half-life paroxetine and venlafaxine cause the worst discontinuation syndromes.

NOTE 'LOT' benzodiazepines (lorazepam, oxazepam, temazepam) have intermediate half-lives and NO active metabolites, making them preferred in hepatic impairment and the elderly.

INCIDENCE & FREQUENCY (COMPREHENSIVE)

Incidence figures across psychiatric and neurogenetic conditions. The source file was blank; this builds the essential incidence set as a key reference. Figures are approximate.

Incidence by Condition

Condition	Incidence / Frequency
Schizophrenia	~15-20 per 100,000/year (lifetime prevalence ~0.3-0.7%)
Late paraphrenia	~17-26 per 100,000/year
Bipolar disorder	~10-15 per 100,000/year
Major depression	Point prevalence ~5%; 12-month ~7%; women > men
NMS	~0.02-3.23% of antipsychotic-treated patients

Condition	Incidence / Frequency
Postpartum psychosis	~1-2 per 1,000 births
Down syndrome	~1 in 800 live births (1 in 1500 if mother <30; 1 in 80 if >40)
Turner syndrome	~1 in 3,300 live female births
Autism spectrum disorder	~1-2% of children (rising ascertainment)
Delirium (hospital)	General medical ~10-30%; post-op >65 ~15-50%; ICU ~70-87%
Alzheimer's (incidence)	Rises steeply with age; roughly doubles every 5 years after 65
Sporadic CJD	~1-2 per million per year
First-episode psychosis	Higher in migrants, urban areas, men

NOTE Schizophrenia incidence (~15-20/100,000/year) is markedly raised in migrants, urban-born, and men - the epidemiological clues that recur in vignettes.

NOTE Down syndrome incidence is strongly maternal-age dependent: ~1 in 1500 under 30, rising to ~1 in 80 over 40.

HOW TO TREAT (SIDE EFFECTS & EMERGENCIES) (COMPREHENSIVE)

Management of drug side effects and psychiatric emergencies - capturing the full source set with additions. Confirm all measures against current protocols.

Management by Problem

Problem	Management
Central anticholinergic (M1) effects	Lower dose; switch to desipramine or SSRI/SNRI/atypical; IV physostigmine for acute emergency
Peripheral anticholinergic effects	Await tolerance; lower dose; bethanechol 25-50 mg bid; sugar-free gum (dry mouth); switch agent

Problem	Management
SSRI sexual dysfunction	Wait 4-6 wk; reduce dose; drug holiday; switch (bupropion, mirtazapine, nefazodone); add PDE-5 inhibitor, bupropion, amantadine, buspirone, cyproheptadine
TCA overdose	Gastric lavage, activated charcoal, sodium bicarbonate (arrhythmias), ECG monitoring, cooling, benzodiazepine for seizures
Noradrenergic crisis (MAOI 'cheese reaction')	Supportive; phentolamine IV; nifedipine 10 mg sublingual or chlorpromazine 50 mg orally to abort
Failure to induce seizure in ECT	Hyperventilate, reduce anaesthetic, remove seizure-threshold-raising drugs, add stimulant (caffeine/theophylline)
Serotonin syndrome	Stop serotonergic drugs, supportive care, benzodiazepines, cyproheptadine; cooling for hyperthermia
NMS	Stop antipsychotic, supportive/cooling, dantrolene, bromocriptine, benzodiazepines; ECT if refractory
Lithium toxicity	Stop lithium, IV fluids/saline, haemodialysis if severe (>2.5 mmol/L or symptomatic)
Acute dystonia	IM/IV anticholinergic (procyclidine/benztropine) or diphenhydramine
Akathisia	Reduce dose; propranolol first-line; benzodiazepine; consider switch
Clozapine-induced agranulocytosis	Stop clozapine immediately, haematology referral, G-CSF, reverse isolation; never rechallenge

NOTE SSRI sexual dysfunction has a stepwise approach: wait, reduce dose, switch (bupropion/mirtazapine), or add an antidote (PDE-5 inhibitor, bupropion, buspirone, or cyproheptadine).

NOTE The MAOI 'cheese reaction' (hypertensive crisis) is aborted with phentolamine, sublingual nifedipine, or chlorpromazine - a classic emergency-management answer.

HYPERSEXUALITY (COMPREHENSIVE)

Conditions and drugs associated with hypersexuality (or altered sexual behaviour) - capturing the full source set with additions.

Causes of Hypersexuality

Condition / Drug	Note
Kluver-Bucy syndrome	Hypersexuality (with placidity, hyperorality, hypermetamorphosis) - bilateral temporal/amygdala lesions
Kleine-Levin syndrome	Hypersexuality with hypersomnia & hyperphagia (episodic)
Mania / bipolar	Increased libido & sexual indiscretion (a core manic symptom)
Frontal lobe / dementia (esp. FTD)	Disinhibited sexual behaviour
Intellectual disability	Sexual disinhibition / inappropriate behaviour
Geschwind syndrome (TLE)	Usually HYPOsexuality, but some cases show hypersexuality
Dopaminergic drugs (levodopa, agonists)	Hypersexuality & compulsive behaviours (esp. D3-preferring ropinirole/pramipexole)
Substances	Stimulants (amphetamines, cocaine), alcohol disinhibition
Huntington's / Parkinson's	Hypersexuality can occur (disease or dopaminergic treatment)
Septal lesions / hypothalamic	Altered sexual behaviour

NOTE Kluver-Bucy syndrome (bilateral temporal lesions) is the classic neurological cause of hypersexuality - paired with placidity, hyperorality, and hypermetamorphosis.

NOTE Note the contrast in temporal-lobe syndromes: Geschwind (interictal TLE) usually causes HYPOsexuality, the opposite of Kluver-Bucy; dopaminergic agonists (ropinirole, pramipexole) cause hypersexuality as an impulse-control side effect.

HYPOCORTISOLAEMIA (COMPREHENSIVE)

Conditions associated with low cortisol / HPA-axis hypoactivity - capturing the source set with additions. Contrasts with the raised cortisol of melancholic depression.

Conditions with Hypocortisolaemia

Condition	Note
PTSD	Low ambient cortisol with high noradrenaline ('adrenal exhaustion' from chronic HPA inhibition)
Chronic fatigue syndrome	HPA-axis hypoactivity / mild hypocortisolism
Fibromyalgia	Blunted HPA response / hypocortisolaemia
Atypical depression	Tends to LOWER HPA activity (vs raised cortisol in melancholic depression)
Addison's disease	Primary adrenal insufficiency - low cortisol; depression, apathy, anhedonia
Seasonal affective disorder	Associated with HPA-axis hypoactivity in some studies

NOTE The classic hypocortisolaemia trio is PTSD, chronic fatigue syndrome, and fibromyalgia - all marked by HPA-axis hypoactivity, in contrast to the HPA OVERactivity (high cortisol, DST non-suppression) of melancholic depression.

NOTE PTSD's paradox - LOW cortisol with HIGH noradrenaline - is attributed to chronic HPA suppression ('adrenal exhaustion') and underlies the exaggerated startle response.

IMAGING - MODALITY OF CHOICE (COMPREHENSIVE)

The imaging modality of choice and characteristic findings for key conditions - capturing the full source set with additions.

Imaging by Condition

Condition / Modality	Finding / Use
FDG-PET	More sensitive than SPECT in separating normal elderly from dementia (temporoparietal & posterior cingulate)

Condition / Modality	Finding / Use
SPECT	~85% accurate differentiating AD, FTD, VaD; HMPAO-SPECT recommended by NICE
MRI	Better resolution than CT; imaging of choice for HSE (temporal-lobe change); detects structural lesions
CT	Detects clinically significant structural lesions; faster, good for acute haemorrhage
Herpes simplex encephalitis	MRI imaging of choice; CSF PCR for HSV is the in vivo gold standard
Wernicke's encephalopathy	MRI (mammillary bodies, periaqueductal); specificity ~93%
Wilson's disease	MRI 'giant panda sign' of the midbrain
vCJD	MRI pulvinar sign (posterior thalamus); sporadic CJD - cortical ribboning, basal ganglia
CNS toxoplasmosis / lymphoma (HIV)	Multiple ring-enhancing lesions on MRI/CT
Alzheimer's disease	MRI medial temporal/hippocampal atrophy; amyloid PET; FDG-PET temporoparietal hypometabolism
Frontotemporal dementia	Frontal/temporal atrophy on MRI; frontal hypometabolism on PET/SPECT

NOTE FDG-PET is more sensitive than SPECT for separating normal ageing from dementia (temporoparietal/posterior cingulate), while HMPAO-SPECT (~85% accurate) is NICE-recommended to differentiate AD, VaD, and FTD.

NOTE Two signature MRI signs: the 'giant panda' sign of the midbrain in Wilson's disease, and the pulvinar (posterior thalamus) sign in variant CJD.

IMPORTANT FEATURES / PATHOGNOMONIC SIGNS (COMPREHENSIVE)

Characteristic and near-pathognomonic features pointing to specific diagnoses - capturing the full source set with additions.

Key Features by Diagnosis

Diagnosis	Important Feature
Vascular dementia	Lacunar lesions; stepwise course; focal neurological signs
Frontotemporal dementia	Localised temporal/frontal lobe atrophy; spongiform change in superficial cortical layers
Creutzfeldt-Jakob disease	Triphasic (periodic sharp-wave) EEG complexes; myoclonus; neuropil vacuolation
Parkinson's / DLB	Loss of dopaminergic neurons in substantia nigra (shared with PD dementia & DLB)
Alzheimer's disease	Neuritic (senile) plaques & neurofibrillary tangles
Hebephrenic schizophrenia	Abnormal mannerisms - e.g. mirror gazing
Inhibited reactive attachment disorder	'Frozen watchfulness'
Lewy body dementia	Fluctuating cognition; visual hallucinations; spontaneous parkinsonism; REM sleep behaviour disorder; neuroleptic sensitivity
Wernicke's encephalopathy	Confusion, ataxia, ophthalmoplegia; mammillary body lesions
Huntington's disease	Caudate atrophy with box-car ventricles; chorea

NOTE Spot-diagnosis features: lacunar lesions → vascular dementia, triphasic EEG complexes → CJD, box-car ventricles → Huntington's, and frozen watchfulness → inhibited reactive attachment disorder.

NOTE Substantia nigra dopaminergic neuron loss is shared across Parkinson's disease, PD dementia, and dementia with Lewy bodies - the unifying 'Lewy' pathology.

DRUG INTERACTIONS (COMPREHENSIVE)

Important psychotropic drug interactions - capturing the source (ECT+lithium) with extensive additions. Confirm against the current BNF.

Key Interactions

Combination	Effect
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Combination	Effect
ECT + lithium	Short-term encephalopathy (confusion/delirium); prolonged seizures - withhold lithium before ECT
MAOI + tyramine (cheese)	Hypertensive crisis ('cheese reaction')
MAOI + SSRI/clomipramine/pethidine/triptans	Serotonin syndrome (needs washout)
SSRI + NSAID/warfarin/aspirin	Increased GI bleeding risk
Lithium + thiazide/NSAID/ACE inhibitor	Reduced lithium clearance → toxicity
Lithium + antipsychotic	Increased neurotoxicity (esp. haloperidol); NMS risk
Clozapine/olanzapine + smoking	Smoking induces CYP1A2 → lower levels (cessation raises levels - toxicity)
Clozapine + ciprofloxacin/fluvoxamine	CYP1A2 inhibition → raised clozapine, seizure risk
Carbamazepine (enzyme inducer)	Lowers levels of OCP, warfarin, lamotrigine, antipsychotics, clozapine
Valproate + lamotrigine	Valproate doubles lamotrigine (rash/SJS) - halve lamotrigine dose
SSRI + tramadol/triptans/St John's Wort	Serotonin syndrome
MAOI + sympathomimetics (decongestants)	Hypertensive crisis
Sodium valproate + carbapenems	Marked reduction in valproate levels
Alcohol + benzodiazepines/opioids	Additive CNS & respiratory depression

NOTE ECT plus lithium can cause a short-term encephalopathy and prolonged seizures - lithium is usually withheld before ECT.

NOTE Smoking induces CYP1A2 and lowers clozapine/olanzapine levels - so smoking CESSATION (or fluvoxamine/ciprofloxacin) can precipitate toxicity by raising levels.

SEX-EXCLUSIVE / SEX-LIMITED DISORDERS (COMPREHENSIVE)

Disorders occurring exclusively or predominantly in one sex - capturing the full source set with additions. A neat genetics/epidemiology topic.

Sex-Exclusive Disorders

Disorder	Sex Distribution
Lesch-Nyhan syndrome	Almost exclusively MALES (X-linked recessive, HPRT)
Fragile X syndrome	Both sexes, but more common & severe in MALES (X-linked)
Rett syndrome	Almost exclusively FEMALES (X-linked dominant, lethal in most males)
Incontinentia pigmenti	Only in females clinically - lethal in male fetuses (X-linked dominant)
Klinefelter syndrome (47,XXY)	Males only (extra X)
Turner syndrome (45,X)	Females only (single X)
Prader-Willi syndrome	Equal female:male ratio (chr 15 paternal)
Angelman syndrome	Equal sexes (chr 15 maternal)
Haemophilia A/B, DMD, colour-blindness	Predominantly males (X-linked recessive) - useful comparators

NOTE Two X-linked mirror images: Lesch-Nyhan (almost exclusively males, X-linked recessive) versus Rett syndrome (almost exclusively females, X-linked dominant, lethal in males).

NOTE Incontinentia pigmenti is seen only in females clinically because it is invariably lethal in male fetuses - a striking X-linked dominant example.

KEYWORDS & BUZZWORDS (COMPREHENSIVE)

Diagnostic 'buzzwords' and pathognomonic descriptors pointing to specific conditions and genetic syndromes - capturing the full source set with additions. A key rapid-recognition reference.

Clinical & Drug Keywords

Condition	Keyword / Buzzword
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Condition	Keyword / Buzzword
Lithium	'Creeping creatinine' (slow renal decline)
MAOI	'Cheese reaction' (tyramine hypertensive crisis)
Pick's disease	Balloon cells, Hirano bodies, knife-blade atrophy, Pick bodies
CJD	Neuropil vacuolation; myoclonic (hypnic) jerks; rapid memory loss + ataxia
Lewy body dementia	Negative for tau, alpha-synuclein positive; fluctuating cognition; dementia with falls & rigidity
Reactive attachment disorder	'Frozen watchfulness'
Hallervorden-Spatz / PKAN	'Tiger's eye' (eye-of-the-tiger) sign on MRI
Nefazodone	'Vision trails' (visual side effect)
Skid-row alcoholic	Life-threatening hypothermia (impaired vasoconstriction in cold)
Wilson's disease	'Giant panda' sign of midbrain on MRI
Smith-Magenis syndrome	Self-hugging; self-injury; sleep disturbance
Schizotypal PD	Obsessions without resistance; magical thinking (ESP/clairvoyance); transient psychotic features
Frontotemporal dementia	Carbohydrate (sweet) craving
GAD	'Feeling on edge all the time'
Phaeochromocytoma	Episodic panic attacks
Cerebellar degeneration	Staccato / scanning speech
Post-concussional syndrome	Slowed mental processing speed

NOTE Spot-diagnosis buzzwords: 'creeping creatinine' → lithium, 'cheese reaction' → MAOI, 'eye of the tiger' → Hallervorden-Spatz, and 'giant panda' → Wilson's disease.

Genetic Syndrome Keywords

Syndrome	Keyword / Buzzword
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Syndrome	Keyword / Buzzword
Rett syndrome	Purposeful hand movements replaced by hand-wringing stereotypies
Angelman syndrome	Happy, laughing much of the time ('happy puppet')
Fragile X syndrome	Socially awkward, gaze avoidance, shyness; cluttering/litanic (jocular) speech, palilalia, social phobia
Prader-Willi syndrome	Insatiable appetite/hyperphagia, obesity, skin-picking, OCD behaviour, mild-moderate LD
Cri-du-chat syndrome	Cat-like (kitten) cry in infancy; inappropriate laughter
Lesch-Nyhan syndrome	Compulsive self-mutilation, self-biting
Cornelia de Lange syndrome	Synophrys (continuous eyebrows), hypertrichosis, thin down-turned lip, self-injury
Phenylketonuria	Musty / 'mouse-like' body odour, fair hair, blue eyes
Williams syndrome	Elfin facies, overfriendly/disinhibited, 'cocktail party' speech, hyperacusis, supraaortic stenosis, hypercalcaemia
Klinefelter syndrome	Lyonsation; tall, hypogonadism, learning difficulties
Tuberous sclerosis	Infantile spasms + autistic behaviours; adenoma sebaceum
Homocystinuria	Ectopia lentis (downward lens dislocation)
CADASIL	Severe migraine + family history of stroke & early dementia
CNS toxoplasmosis/lymphoma (HIV)	Multiple ring-enhancing lesions on MRI

NOTE Genetic-syndrome buzzwords: 'cat-like cry' → cri-du-chat, 'happy puppet' → Angelman, 'cocktail party speech/elfin facies' → Williams, 'mouse-like odour' → PKU, and insatiable appetite → Prader-Willi.

MECHANISM OF ACTION (COMPREHENSIVE)

Mechanisms of action of psychotropic drugs (after Stahl) - capturing the full source set with additions. A core psychopharmacology reference.

Mechanism of Action by Drug

Drug	Mechanism of Action
Acamprosate	Reduces excitatory glutamate, enhances inhibitory GABA neurotransmission
Agomelatine	Melatonergic (MT1/MT2) agonist + 5-HT _{2C} antagonist (raises frontal NA/DA)
Amisulpride	Low dose blocks presynaptic D ₂ (↑ DA); higher dose blocks postsynaptic D ₂ ; 5-HT _{7/2B} antagonist; D ₃ block; NO 5-HT _{2A} action
Aripiprazole	D ₂ partial agonist + 5-HT _{1A} partial agonist + 5-HT _{2A} antagonist
Buprenorphine	Partial mu-agonist + kappa antagonist
Bupropion	NA & DA reuptake inhibition; nicotinic ACh antagonist
Buspirone	5-HT _{1A} partial agonist (pre- & postsynaptic); mixed DA agonist/antagonist
Carbamazepine	Use-dependent blockade of voltage-gated Na ⁺ channels; inhibits glutamate release
Lithium	Inhibits GSK-3 & inositol monophosphatase; modulates glutamate; regulates PKC signalling; ↑ NA/5-HT
Valproate	Enhances GABA (inhibits GABA-transaminase), blocks Na ⁺ channels, ↓ NMDA glutamate, PKC & HDAC effects, ↑ BDNF
Lamotrigine	Inhibits glutamate release at NMDA & blocks voltage-sensitive Na ⁺ channels
Topiramate	Blocks Na ⁺ channels + inhibits carbonic anhydrase (metabolic acidosis)
Varenicline	Partial agonist at alpha4beta2 nicotinic ACh receptor
Naltrexone	Mu-opioid antagonist (kappa agonist)

Drug	Mechanism of Action
Modafinil	Activates orexin/hypothalamic arousal; ↑ DA/NA/5-HT; activates glutamate, inhibits GABA
Caffeine	Adenosine receptor antagonist (↑ intraneuronal cAMP); a methylxanthine
Amphetamine	Releases stored monoamines (NA & DA) - central sympathomimetic
Alcohol	↓ NMDA sensitivity, ↑ GABA, downregulates Ca ²⁺ channels, upregulates nicotinic receptors
PDE-5 inhibitors (sildenafil)	Block cGMP degradation → smooth-muscle relaxation → erection
Apomorphine	D1 & D2 dopamine agonist (central; erectile dysfunction)
Yohimbine	Selective alpha-2 adrenergic antagonist (central action in ED)
Ropinirole / pramipexole	D2/D3/D4 agonist (D3-preferring) - PD/RLS; hypersexuality & gambling side effects
Cyproheptadine	Sedating antihistamine with 5-HT _{2A} antagonist & antimuscarinic action (serotonin syndrome antidote)
Alprazolam	Binds benzodiazepine site on GABA-A chloride channel; enhances inhibitory GABA
Amitriptyline	Blocks 5-HT and NA reuptake (and can raise frontal DA); also antihistaminic/antimuscarinic
Atomoxetine	Selective NA reuptake inhibitor; raises NA and frontal DA (non-stimulant ADHD agent)
Benztropine	Central antimuscarinic (counters excess ACh when D2 blocked); also blocks DA reuptake
Cariprazine	D3-preferring D2/D3 partial agonist + 5-HT _{1A} partial agonist + 5-HT _{2B} antagonist

Drug	Mechanism of Action
Mirtazapine	Alpha-2 antagonist; 5-HT _{1A} agonism, 5-HT _{2A/2C/3} antagonism; H ₁ antagonist (NaSSA)
Baclofen	GABA-B receptor agonist
Pregabalin / gabapentin	Bind alpha-2-delta subunit of voltage-gated Ca ²⁺ channels (close N & P/Q channels); NO direct GABA action despite structure
Acamprosate	Reduces NMDA glutamate transmission, lowers Ca ²⁺ influx, modulates mGluR5 (anti-craving in alcohol)
Naltrexone	Mu-opioid antagonist, kappa agonist (relapse prevention in alcohol/opioid)
Methadone	Full mu-opioid agonist (opioid substitution)
Propofol	Increases GABA-mediated inhibitory tone in the CNS
Levodopa	Crosses blood-brain barrier, decarboxylated to dopamine (Parkinson's)
Bromocriptine / pramipexole	Dopamine receptor agonists (PD/RLS; sleep attacks, impulse-control disorders)
Apomorphine	D ₁ & D ₂ dopamine agonist (erectile dysfunction; PD rescue)
Alprostadil	Prostaglandin E ₁ → raises cAMP → smooth-muscle relaxation/vasodilation (erection)
Doxepin	Potent antihistamine (H ₁) - used for pruritus/urticaria and as low-dose hypnotic
Cyproheptadine	Antihistamine with 5-HT _{2A} antagonism & antimuscarinic action (serotonin syndrome antidote)
Physostigmine	Indirect parasympathomimetic (anticholinesterase) - antidote for anticholinergic toxicity
Phentolamine	Alpha-adrenergic blocker
Botulinum toxin	Inhibits acetylcholine release from presynaptic terminals

Drug	Mechanism of Action
Rimonabant	Selective cannabinoid CB1 receptor antagonist (withdrawn anti-obesity agent)
Cocaine	Blocks presynaptic DAT/NET/SERT -> raises synaptic monoamines
Amphetamine / methamphetamine	Releases stored NA & DA, reverses transporters (NET/DAT, VMAT2, MAO)
Nicotine	nAChR (alpha-4-beta-2) agonist -> disinhibits VTA dopamine neurons
Opioids (morphine/heroin)	Mu-receptor agonists -> disinhibit GABAergic neurons - > raise DA
Cannabis	CB1 agonist -> disinhibits VTA dopamine neurons via GABAergic interneurons
Hallucinogens	5-HT2A receptor agonism (plus broad DA receptor activity)

NOTE Pregabalin and gabapentin are gabapentinoids that, despite their GABA-like structure, have NO direct action on GABA receptors - they bind the alpha-2-delta subunit of voltage-gated calcium channels to reduce excitatory neurotransmitter release.

NOTE Cyproheptadine and cyproheptadine-like antihistamines with 5-HT2A antagonism are used as the antidote in serotonin syndrome; physostigmine is the antidote in central anticholinergic toxicity.

NOTE Amisulpride is mechanistically unusual: at low doses it blocks PRESYNAPTIC D2 autoreceptors (raising dopamine, helping negative symptoms), and unlike other atypicals it has NO significant 5-HT2A action.

NOTE Aripiprazole, brexpiprazole, and cariprazine are D2 PARTIAL agonists ('dopamine system stabilisers'), distinguishing them from the pure D2 antagonism of other antipsychotics.

MAXIMUM DOSES (COMPREHENSIVE)

Maximum licensed daily doses of psychotropic drugs (after the Maudsley Guidelines) - capturing the full source set with additions. Always confirm against the current BNF/Maudsley before prescribing.

Maximum Doses

Drug	Maximum Dose
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Drug	Maximum Dose
Chlorpromazine	1000 mg/day
Haloperidol	20 mg/day (oral)
Sulpiride	2400 mg/day
Pimozide	20 mg/day
Amisulpride	1200 mg/day
Aripiprazole	30 mg/day
Clozapine	900 mg/day
Olanzapine	20 mg/day
Quetiapine	750 mg/day (schizophrenia), 800 mg/day (bipolar)
Risperidone	16 mg/day
Lurasidone	160 mg/day
Citalopram / escitalopram	40 mg/day / 20 mg/day
Fluoxetine	80 mg/day
Sertraline	200 mg/day
Paroxetine	60 mg/day
Fluvoxamine	300 mg/day
Venlafaxine	375 mg/day
Duloxetine	120 mg/day
Mirtazapine	45 mg/day
Bupropion	450 mg/day
Trazodone / nefazodone	600 mg/day each
Amitriptyline / imipramine / clomipramine / doxepin	300 mg/day
Nortriptyline	150 mg/day
Phenelzine / tranylcypromine	90 mg/day / 60 mg/day

Drug	Maximum Dose
Lithium	2400 mg/day
Valproate	60 mg/kg/day (NICE: limit to 1000 mg/day; pregnancy max 1000 mg)
Carbamazepine	1600 mg/day
Topiramate	500 mg/day
Pregabalin / gabapentin	600 mg/day / 3600 mg/day
Atomoxetine	100 mg/day
Buspirone	60 mg/day
Procyclidine	30 (up to 60) mg/day
Flupentixol	18 mg/day
Levomepromazine	1000 mg/day
Pericyazine	300 mg/day
Perphenazine	24 mg/day
Trifluoperazine	None licensed (suggest 30 mg/day)
Zuclopenthixol	150 mg/day
Asenapine	20 mg/day (sublingual)
Paliperidone	12 mg/day
Brexpiprazole	6 mg/day
Cariprazine	6 mg/day
Iloperidone	24 mg/day
Molindone	225 mg/day
Ziprasidone	200 mg/day
Sertindole	24 mg/day
Aripiprazole depot	400 mg/month
Flupentixol decanoate depot	400 mg/week

Drug	Maximum Dose
Fluphenazine decanoate depot	100 mg every 2 weeks
Haloperidol decanoate depot	300 mg every 4 weeks
Paliperidone palmitate (1-monthly)	150 mg/month
Paliperidone palmitate (3-monthly)	525 mg every 3 months
Pipotiazine depot	200 mg every 4 weeks
Risperidone LAI	50 mg every 2 weeks
Zuclopenthixol decanoate depot	600 mg/week
Zuclopenthixol acetate (acuphase)	400 mg per 2 weeks
Desvenlafaxine	400 mg/day
Vortioxetine	20 mg/day
Levomilnacipran	120 mg/day
Amoxapine	400 mg/day
Maprotiline	150 mg/day
Desipramine	300 mg/day
Protriptyline	60 mg/day
Selegiline transdermal	12 mg/day
Isocarboxazid	30 mg/day
Levetiracetam	3000 mg/day
Biperiden	16 mg/day
Guanfacine	4 mg/day
Desmopressin	0.6 mg (in children)

NOTE Depot/LAI ceilings are tested frequently: aripiprazole 400 mg/month, haloperidol decanoate 300 mg/4 weeks, paliperidone palmitate 150 mg/month (1-monthly) or 525 mg/3 months (3-monthly), and risperidone LAI 50 mg/2 weeks.

NOTE Two low ceilings worth memorising for safety: citalopram 40 mg/day and escitalopram 20 mg/day (QT prolongation), both lower in the elderly.

NOTE NICE recommends limiting valproate to 1000 mg/day (and avoiding it in women of childbearing potential), despite a higher theoretical maximum of 60 mg/kg/day.

SEX RATIOS (COMPREHENSIVE)

Sex ratios across psychiatric disorders - female-predominant, male-predominant, and roughly equal. Capturing the full source set with additions; a key epidemiology topic.

Female-Predominant

Disorder	F:M Ratio
Anorexia / bulimia nervosa	F:M ~10:1
Trichotillomania	F ~9:1
Late paraphrenia	F ~7:1
Depression / dysthymia	F ~2:1
Agoraphobia	F ~3:1
Panic disorder	F ~3:2
GAD	F ~2:1
PTSD	F ~2:1
Borderline PD	F ~3:1
Late-onset psychosis	F ~3:1
Alzheimer's	F ~3x
Fibromyalgia / MS / Pick's / somatization	F ~2-3:1
Rapid-cycling bipolar / bipolar II	Female predominance
Kleptomania, RLS, clozapine agranulocytosis	Female predominance
Body dysmorphic disorder	F ~3:1
Dermatillomania (skin-picking)	Female predominance

Disorder	F:M Ratio
Munchausen syndrome (factitious)	Female predominance
Depersonalization / dissociative amnesia	Female predominance
Dissociative identity disorder	Female predominance
Selective mutism / school refusal	Female predominance
Adjustment disorder (children)	Female predominance
Binge-eating disorder	Female predominance
Postpartum depression	Female (by definition / strong excess)
Hypochondriasis / somatic symptom disorder	Roughly F-predominant (somatization 2:1)
Prepubertal depression	Female predominance
Specific phobia	Female predominance
Synaesthesia	Female predominance
Oniomania (compulsive buying)	Female predominance
Night terrors	Female predominance

NOTE Eating disorders show the strongest female predominance (~10:1 for both anorexia and bulimia), with trichotillomania (~9:1) and late paraphrenia (~7:1) close behind.

Male-Predominant

Disorder	M:F Ratio
Alcoholism	M ~8:1
Antisocial PD	M ~6:1
Conduct disorder	M ~4:1 (up to 9:1)
Autism	M ~4:1
Asperger's	M ~10:1
ADHD / hyperkinetic	M ~2:1

Disorder	M:F Ratio
Substance misuse	M ~3:1
Pyromania	M ~8:1
Pathological gambling	M ~3:1
Disorders of sexual preference (paraphilias)	M ~30:1
Suicide (most countries except China)	Male predominance (old age ~3:1)
Enuresis / morbid jealousy	M ~2:1
Cocaine use / intermittent explosive disorder	M ~2:1
Fragile X, DMDD, Tourette's, REM behaviour disorder	Male predominance
Narcolepsy	Slight male predominance
REM sleep behaviour disorder	Strong male predominance
Tourette's / stammering	Male predominance
Specific learning disorder	Male predominance
Disruptive mood dysregulation disorder	Male predominance
Transvestic fetishism	Almost exclusively male
Kleine-Levin syndrome	Male predominance (~3:1)
Stuttering at onset	Male predominance
Head-banging	Male predominance
Premature ejaculation	Male (by definition)
Nocturnal enuresis	Male ~2:1

NOTE The strongest male predominance is in paraphilias (~30:1), then Asperger's (~10:1), conduct disorder/pyromania/alcoholism (~8-9:1), and antisocial PD (~6:1).

Roughly Equal

Disorder	Note
Lifetime risk of schizophrenia	Approximately equal (men earlier onset)
Bipolar I disorder	Approximately equal (bipolar II ~1.3:1 female)
OCD (adults)	Equal (commoner in boys in childhood)
Social phobia	Roughly equal (slight female excess in community)
Prader-Willi / Angelman	Equal sexes
Late-onset psychosis (vs late paraphrenia F-predom.)	Distinguish from female-predominant late paraphrenia
Bipolar II	~1.3:1 female

NOTE Two reliable extremes for exams: paraphilias/disorders of sexual preference are the most male-predominant (~30:1), while eating disorders are the most female-predominant (~10:1).

NOTE Bipolar I and the lifetime risk of schizophrenia are roughly equal between the sexes; OCD is equal in adults but commoner in boys during childhood.

MORTALITY RATES (COMPREHENSIVE)

Mortality rates and standardised mortality ratios (SMRs) across psychiatric emergencies and disorders - capturing the full source set with additions. Figures vary between studies.

Emergencies & Acute Conditions

Condition	Mortality
Neuroleptic malignant syndrome	~5-20% (up to 70% with complications)
Serotonin syndrome (severe)	~2-12% (most commonly renal failure)
Delirium tremens	Treated ~0-1% (modern ICU); untreated up to ~15-35%
Wernicke's encephalopathy	~17-20% if untreated; 10-20% even with thiamine (early studies)
Hypertensive crisis (MAOI)	~1 in 100,000 patients die
Clozapine-induced myocarditis	Up to ~50%
Clozapine agranulocytosis (case fatality)	~3% of those who develop it

Condition	Mortality
Herpes simplex encephalitis	~70% untreated; 20-30% with IV aciclovir

NOTE Delirium tremens mortality has fallen dramatically with ICU care - from historical figures of 15-35% untreated to ~0-1% treated - one of the clearest examples of treatment changing prognosis.

Disorders (SMRs)

Disorder	Mortality / SMR
Anorexia nervosa	~5-10% over 10 years (untreated up to 20%); $\frac{2}{3}$ from direct effects, $\frac{1}{3}$ suicide - most lethal psychiatric disorder
Bulimia nervosa	Standardised mortality ratio (SMR) ~1.93 (lower than anorexia)
Major depression	SMR ~20x expected
Bipolar (manic-depression)	SMR ~15x expected
Dysthymia	SMR ~12x general population
Schizophrenia	SMR ~2.6 (2-3x risk of dying); increasing trend
Bipolar disorder	SMR ~2.6 (same as schizophrenia)
Antisocial personality disorder	SMR ~8-9
Panic disorder	All-cause mortality ~1.9x (SMR)
Alcohol-related disorders	~3x general population (accidents, cirrhosis, suicide, etc.)
Delirium	Hospital mortality ~6-18% (2x matched controls); ~40% die within 1 year; 1-yr mortality up to ~50%
Marchiafava-Bignami disease	Type A (whole corpus callosum) ~21%; Type B (partial) ~5%

NOTE Anorexia nervosa is the most lethal psychiatric disorder (~5-10% over a decade; up to 20% untreated), with two-thirds of deaths from direct effects and one-third from suicide.

NOTE Mood-disorder SMRs are striking: major depression ~20x and bipolar ~15x expected mortality, while both schizophrenia and bipolar carry an SMR around 2.6.

PREVALENCE (COMPREHENSIVE)

Prevalence figures across psychiatric disorders - capturing the full source set with additions. A core epidemiology reference; figures are approximate and population-dependent.

Major Disorders

Disorder	Prevalence
OCPD	Most common PD; ~7-8% of general population
Avoidant PD	~2%
Dependent PD	~0.5-1%
Schizophrenia (lifetime)	~0.3-0.7%; rare in children (~1 in 1000); elderly ~1%
Schizoaffective disorder	~0.3% (one-third as common as schizophrenia; higher in women)
Major depression	12-month ~7%; 18-29 yr 3x the >60 yr rate; F 1.5-3x M
PMDD	12-month ~1.8-5.8% of menstruating women
Postpartum blues / depression / psychosis	Blues up to ~85%; depression ~15%; psychosis ~1-2/1000
Learning disability (IQ <70)	~3.7%; self-injury 20% (50% in institutions)
Substance-related disorder (lifetime)	~27% (excluding nicotine)
Alcohol use disorder	12-month ~5% teens, up to 9% adults; US lifetime ~13.6%
Cannabis use disorder	12-month ~3.5% adolescents, ~1.5% adults (M 2-3x F)
Down / Turner syndrome	Down ~1/800 live births; Turner ~1/3300 live female births

NOTE OCPD is the commonest personality disorder (~7-8%); among the psychoses, schizoaffective disorder is about one-third as common as schizophrenia (~0.3%).

Anxiety, Behavioural & Special Groups

Disorder	Prevalence
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Disorder	Prevalence
Social anxiety disorder (lifetime)	~10.7%
Separation anxiety disorder (lifetime)	~6.7%
GAD (lifetime)	~4.3%
Panic disorder (lifetime)	~3.8%
Agoraphobia (lifetime)	~2.5% (lowest among anxiety disorders)
Excoriation disorder	~2.0-5.4%
RLS	~3-15% of the general population
DSH in possible psychosis (lifetime)	~25%
Dissociative fugue	~0.2% (general population)
Pedophilic disorder (males, max estimate)	~3-5%
Suicidal ideation / plan / attempt (lifetime, cross-national)	~9.2% / 3.1% / 2.7%
Anxiety in old age (1-month)	Phobic ~10%, GAD ~4%, panic <1%
Depression in elderly	Community 3-15%; GP attenders & care homes 15-20%; inpatients ~20%
Delirium in cancer	~44% inpatients, rising to ~62% near death
Any mental disorder in HIV (lifetime)	~38-73%
Mental disorder in Europe	Lifetime ~1 in 4; 12-month ~1 in 10

NOTE Among the anxiety disorders, social anxiety disorder has the highest lifetime prevalence (~10.7%) and agoraphobia the lowest (~2.5%).

Key NICE (and Maudsley) guideline recommendations across psychiatric disorders - capturing the full source set with additions. Reflects UK guidance; confirm against the current version.

NICE Recommendations by Topic

Topic	Recommendation
PTSD	No debriefing; watchful waiting if mild <4 weeks; trauma-focused CBT or EMDR first-line; drugs NOT routine first-line (paroxetine/mirtazapine for general use, amitriptyline/phenelzine specialist-only)
Depression - general	SSRI preferred; not first-line for mild (use guided self-help/CBT/exercise); antidepressants for moderate-severe & dysthymia; combine with CBT/IPT in severe
Depression - continuation	Continue ≥6 months after remission; ≥2 years if ≥2 prior episodes
Depression - non-response	Check compliance; switch to a different SSRI or better-tolerated newer antidepressant
Panic disorder	SSRI first-line; if contraindicated/no response at 12 weeks → imipramine or clomipramine
Anorexia nervosa	Aim weight gain 0.5-1 kg/week inpatient, 0.5 kg/week outpatient
ADHD - school-age mild/moderate	Group-based parent-training first; medication if severe
First-episode psychosis (child/young person)	Oral antipsychotic + psychological intervention (family intervention + individual CBT)
Depression in pregnancy	Maudsley: fluoxetine, imipramine, nortriptyline (avoid paroxetine); fluoxetine = lowest-risk SSRI
Harmful drinking (brief intervention)	FRAMES-based brief structured advice (Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy)
Alcohol (mild dependence/harmful)	Acamprosate or naltrexone + psychological intervention if no response to psychology alone
Fluoxetine → mirtazapine switch	Cautious cross-taper; start mirtazapine 15 mg, gradually reduce fluoxetine

Topic	Recommendation
Valproate dose	Limit to 1000 mg/day
Rapid tranquillisation (children/adolescents)	Intramuscular lorazepam
Bulimia nervosa	Evidence-based guided self-help first-line; +/- antidepressant (fluoxetine 60 mg, higher than for depression); CBT-BN (16-20 sessions over 4-5 months); IPT as alternative but slower (8-12 months)
OCD in young people	Mild -> guided self-help, then CBT+ERP; moderate/severe -> CBT+ERP first, then combine with SSRI (or alternative SSRI / clomipramine)
OCD - SSRI+CBT non-response	Switch to a different SSRI or clomipramine; if still ineffective, intensive CBT or add a low-dose antipsychotic (switching prioritised before antipsychotic)
Body dysmorphic disorder	CBT first; add an SSRI if severe (Maudsley: buspirone may augment the SSRI)
Depression in children/adolescents	If initial psychological therapy fails, switch to an alternative (CBT/IPT/family therapy); fluoxetine if patient/carers accept; individual or systemic family therapy after two failed psychotherapies
Bipolar depression	SSRI first-line for depressive episodes, given IN ADDITION to an antimanic agent
Rapid-cycling bipolar	Combination of lithium and valproate as first-line
Bipolar in breastfeeding	Avoid breastfeeding on lithium, benzodiazepines, or lamotrigine; prefer an antipsychotic prophylactic (not clozapine); if antidepressant needed use an SSRI (not fluoxetine or citalopram)
Opioid detoxification (inpatient)	Shorter than community: methadone ~14-21 days, buprenorphine ~7-14 days

Topic	Recommendation
Alcohol in pregnancy (CG62)	Avoid alcohol in first 3 months (miscarriage risk); if drinking, no more than 1-2 UK units once/twice weekly; avoid binge drinking (>7.5 units)
Parkinson's disease - new psychosis	First reduce the anti-Parkinson drugs that may have triggered it (specialist advice); haloperidol contraindicated; quetiapine if needed; start cholinesterase inhibitor first if not already on one
Dementia with Lewy bodies	Donepezil or rivastigmine first-line; galantamine only if these not tolerated; memantine if AChE inhibitors contraindicated/not tolerated
Dementia - investigations	Bloods (FBC, biochemistry, Ca, glucose, renal/liver), TFTs, B12 & folate; structural imaging (MRI preferred) to exclude pathology & subtype; HMPAO-SPECT or FDG-PET if subtype in doubt; FP-CIT SPECT for suspected DLB
Treatment-resistant depression	Augment with lithium, an antipsychotic, or a second antidepressant; ECT for severe/treatment-resistant depression

NOTE For bulimia nervosa, the effective fluoxetine dose (60 mg/day) is HIGHER than for depression, and antidepressants are the only drug class NICE recommends for the disorder.

NOTE Across OCD and BDD, NICE prioritises switching/psychological optimisation BEFORE adding a low-dose antipsychotic - a commonly tested sequencing point.

NOTE For PTSD, NICE is explicit: do NOT offer debriefing, and offer trauma-focused CBT or EMDR first-line - drugs (paroxetine/mirtazapine) are reserved for those declining psychological therapy.

NOTE NICE depression continuation rules are frequently tested: continue antidepressants at least 6 months after remission, extending to at least 2 years for those with two or more prior episodes.

PARTIAL AGONISTS (COMPREHENSIVE)

Partial agonist psychotropic drugs and their receptor targets - the source file was blank; this builds the essential set as a key pharmacology reference.

Partial Agonists

Drug	Receptor Action
Aripiprazole	D2 & D3 partial agonist + 5-HT1A partial agonist + 5-HT2A antagonist ('dopamine system stabiliser')
Brexpiprazole	D2 partial agonist + 5-HT1A partial agonist (less akathisia than aripiprazole)
Cariprazine	D3-preferring D2/D3 partial agonist + 5-HT1A partial agonist
Buspirone	5-HT1A partial agonist (anxiolytic; no dependence)
Buprenorphine	Partial mu-opioid agonist (+ kappa antagonist) - ceiling effect on respiratory depression
Varenicline	alpha4beta2 nicotinic ACh receptor partial agonist (smoking cessation)
Pindolol	5-HT1A partial agonist / beta-blocker - augmentation in depression
Pramipexole	D3-preferring dopamine agonist (full, not partial) - comparator
D-cycloserine	NMDA-receptor partial (glycine-site) agonist - augments exposure therapy
Aripiprazole vs others	Partial agonism gives functional antagonism in high-dopamine states & functional agonism in low-dopamine states

NOTE The '-piprazole' antipsychotics (aripiprazole, brexpiprazole, cariprazine) are D2 partial agonists ('dopamine system stabilisers') - functionally antagonist in high-dopamine states and agonist in low-dopamine states.

NOTE Buprenorphine's partial mu-agonism gives a ceiling effect on respiratory depression, making it safer in overdose than full agonists like methadone.

POOR PROGNOSTIC FACTORS (COMPREHENSIVE)

Poor prognostic factors across psychiatric disorders - capturing the full source set with additions. A key prognosis reference.

Poor Prognostic Factors

Disorder	Poor Prognostic Factors
Schizophrenia	Early/insidious onset, male, poor social support/unmarried, no stressor, chronic >2 yr, poor premorbid adjustment, negative symptoms, family history, flat affect, poor treatment response
Depression	Persistent dysthymia, psychiatric/medical comorbidity, female, longer episodes before treatment, ≥3 prior episodes, never married
Anorexia nervosa	Older onset, lower weight, frequent vomiting/bulimia, severe weight loss, long duration, prior hospitalisation, treatment resistance, family problems, neurotic personality, male
Bulimia nervosa	Depression, personality disturbance, greater symptom severity, longer duration, low self-esteem, substance abuse, childhood obesity
OCD	Yielding to (not resisting) compulsions, childhood onset, bizarre compulsions, need for hospitalisation, comorbid depression, delusional beliefs, overvalued ideas, comorbid PD (esp. schizotypal)
Antisocial PD	Felony arrest, repeated lying/aliases/conning, unresolved legal situation, felony conviction, hospitalisation instead of prison, violence to others, comorbid organic brain impairment
Borderline PD	Social dysfunction, severe childhood trauma, persistent substance abuse
Chronic fatigue syndrome	Focus on symptoms, psychiatric comorbidity, poor sense of control, passivity, secondary gain (disability benefit), older age, belief in purely physical cause, belief that rest is curative, self-help group membership
Factitious disorder	Better with comorbid mood/anxiety/substance disorder; WORSE with comorbid personality disorder (esp. antisocial)

Disorder	Poor Prognostic Factors
Post-head-injury psychiatric morbidity	Long post-traumatic amnesia, long loss of consciousness, older age, chronic alcohol use
ADHD	Early stressful experiences (poverty, overcrowding), high expressed emotion, parental psychopathology, hyperactive-impulsive type, comorbid conduct/language/learning disorder
Alzheimer's disease	Significant language impairment, poor cognition, parietal lobe involvement, reduced left parietal density on CT
Vascular dementia	Severity of dementia, being bedridden, urinary incontinence
PTSD	Comorbid alcohol use, female sex, comorbid learning disability, greater numbing, comorbid post-concussion syndrome

NOTE Schizophrenia's poor-prognosis cluster (early/insidious onset, male, negative symptoms, poor premorbid adjustment, no precipitating stressor, family history) is one of the most-tested lists in psychiatry.

NOTE Chronic fatigue syndrome prognosis worsens with a strong belief in a purely physical cause, the belief that rest is curative, secondary gain (disability benefit), and self-help group membership.

MEDIAN AGE OF ONSET (COMPREHENSIVE)

Median (and mean) ages of onset, focusing on the anxiety disorders and mood disorders - capturing the full source set with additions.

Median Age of Onset

Disorder	Median / Mean Age
Social anxiety disorder	Median onset ~15 years (youngest among anxiety disorders)
Separation anxiety disorder	Median ~16 years
Specific phobia	~8-12 years
Agoraphobia	Median ~18 years

Disorder	Median / Mean Age
Panic disorder	Median ~23 years
GAD	Median ~30 years (Harvard/Brown: mean ~21, long duration before evaluation)
Bipolar disorder (ECA)	Mean onset ~21 years
Unipolar depression (ECA)	Mean onset ~27 years
Unipolar → bipolar switch	Mean age ~32 years (after 2-4 prior episodes)
Schizophrenia	Men early 20s; women late 20s
Alzheimer's disease	Usually after 65 years

NOTE Among the anxiety disorders, social anxiety disorder has the YOUNGEST median onset (~15 yr) and GAD the oldest (~30 yr) - a frequently tested ordering.

NOTE The ECA study anchors the mood-disorder ages: bipolar mean onset ~21 years versus unipolar depression ~27 years.

DRUG METABOLITES (COMPREHENSIVE)

Active and inactive metabolites of psychotropic and other drugs - capturing the full source set with additions. Relevant to drug testing, duration of action, and toxicity.

Drugs & Their Metabolites

Drug	Metabolite(s)
Cocaine	Benzoyllecgonine (inactive) - detectable in urine 2-5 days; basis of urine testing
Ketamine	Norketamine (active metabolite)
Chlordiazepoxide	Demoxepam and nordazepam (long-acting active metabolites)
Diazepam	Desmethyldiazepam (nordazepam), temazepam, oxazepam (active)
Paracetamol	NAPQI (benzoquinoneimine) - toxic metabolite; depletes glutathione → hepatotoxicity

Drug	Metabolite(s)
Donepezil	6-O-desmethyl-donepezil (active) - ~20% of plasma concentration
Fluoxetine	Norfluoxetine (active, long half-life 7-15 days)
Venlafaxine	O-desmethylvenlafaxine (desvenlafaxine; active)
Risperidone	9-hydroxyrisperidone (paliperidone; active)
Amitriptyline / imipramine	Nortriptyline / desipramine (active secondary amines)
Carbamazepine	Carbamazepine-10,11-epoxide (active)
Diamorphine (heroin)	6-monoacetylmorphine then morphine (active)
Codeine	Morphine (via CYP2D6 - poor metabolisers get little effect)
Primidone	Phenobarbital & PEMA (active)

NOTE Benzoyllecgonine (inactive) is the cocaine metabolite detected in urine for 2-5 days - the basis of cocaine urine testing; norfluoxetine is the long-acting active metabolite that makes fluoxetine self-tapering.

NOTE Several active metabolites became drugs in their own right: desvenlafaxine (from venlafaxine) and paliperidone (9-hydroxyrisperidone, from risperidone).

NOVEL & EMERGING TREATMENTS (COMPREHENSIVE)

Novel, off-label, and emerging treatments in psychiatry - capturing the full source set with additions. Several remain investigational; confirm regulatory status.

Novel Treatments by Condition

Condition	Novel / Emerging Treatment
Treatment-resistant depression	High-dose buspirone (up to 90 mg), amantadine, buprenorphine, ketoconazole ('hypercortisolaemic depression'); esketamine, psilocybin (trials)
Parkinson's disease psychosis	Pimavanserin (FDA-approved 5-HT _{2A} inverse agonist)
Alcohol withdrawal	Dexmedetomidine (alpha-2 agonist) adjunct - no respiratory depression but does NOT reduce seizures

Condition	Novel / Emerging Treatment
OCD (refractory)	Second-generation antipsychotic augmentation; glutamate-targeting agents; d-cycloserine + CBT; ketamine (mixed evidence)
PTSD	MDMA-assisted psychotherapy (phase 2/3 trials)
Postpartum depression	Brexanolone & zuranolone (neuroactive steroid GABA-A modulators)
Treatment-resistant depression (device)	rTMS, VNS, deep brain stimulation; ketamine/esketamine
Negative symptoms / cognition	Glutamatergic & nicotinic agents (investigational)
Tardive dyskinesia	VMAT2 inhibitors (valbenazine, deutetrabenazine)
Narcolepsy	Pitolisant (H3 inverse agonist), solriamfetol

NOTE Glutamate-targeting agents are a major frontier: ketamine/esketamine for treatment-resistant depression, and d-cycloserine (an NMDA partial agonist) to augment exposure therapy in OCD and anxiety.

NOTE MDMA-assisted psychotherapy (phase 2/3 trials) for PTSD and neuroactive-steroid GABA-A modulators (brexanolone, zuranolone) for postpartum depression are among the most prominent recent developments.

MOST COMMON (COMPREHENSIVE)

'Most common' facts across psychiatry - the single commonest symptom, cause, comorbidity, or association for a wide range of topics. Capturing the full (large) source set with additions; a very key single-best-answer reference.

Most Common Associations

Topic	Most Common
Crime in ASD	Arson/fire-setting (the over-represented offence)
Psychiatric disorder in elderly women (community)	Phobias
Symptom in Wernicke's	Confusion (~80%; ophthalmoplegia ~30%, cerebellar ~23%, full triad ~10%)

Topic	Most Common
Diagnosis in prison population	Personality disorder (esp. antisocial)
Diagnosis in homicide offenders	Personality disorder (alcohol/drug dependence overall commonest psychiatric problem)
PD linked to suicide in over-60s	Anankastic (obsessive-compulsive) personality disorder
Commonest PD (UK)	Anankastic (1.7-2.2%), then anxious, then borderline
Young-onset dementia (30-64)	Alzheimer's, then vascular, then frontotemporal
Comorbidity of depression	Most likely of all disorders to be comorbid with another
Symptom in panic disorder	Palpitations
Most disabling PD (occupational)	Dissocial (antisocial) personality disorder
Commonest comorbidity of hypochondriasis	GAD (71%)
Commonest benzodiazepine withdrawal symptom	Anxiety (then insomnia, excitability, irritability)
Most abused substance by adolescents	Alcohol (~30% of 13-yr-olds weekly)
PD in primary care	Cluster C commonest; anankastic the single commonest ICD type, then impulsive
Drug for Lewy body dementia + psychosis	Rivastigmine
Behavioural symptom in Alzheimer's	Apathy (59.6%), then depression (58.5%); commonest psychotic symptom = delusions
Disorder in hospital self-harm presentations	Depression (>90% have a mental disorder)
Imaging of choice in HSE	MRI
Commonest SSRI side effect	Sexual dysfunction (~60%)
Borderline PD symptom course	Impulsive symptoms resolve quickest; affective symptoms most chronic

Topic	Most Common
Inherited cause of learning disability	Fragile X (commonest inherited); fetal alcohol = commonest environmental; Down = commonest overall (but sporadic)
Disorders in sex offenders	Personality disorder, paraphilias, alcohol/substance misuse (severe mental illness rare)
Commonest rivastigmine side effects	Nausea, vomiting, diarrhoea, dizziness, anorexia
Comorbidity of autism in children	ADHD
Early complaint in PSP	Unsteady gait & unexplained falls (retropulsion)
Commonest sexual disorder in men	Premature ejaculation (a disorder of orgasm)
Prader-Willi behavioural phenotype	Increased appetite + incessant skin-picking
Commonest cause of major NCD	Alzheimer's disease
Narcolepsy-cataplexy HLA	HLA-DQB1*06:02; low CSF orexin
Commonest psychiatric disorder in HIV	Depression (~40%); commonest cause of psychiatric hospitalisation post-HAART
Risk factor for dissociative disorders	History of trauma (esp. childhood maltreatment)
Reason to seek treatment in separation anxiety	School refusal (esp. adolescents)
Blood picture in anorexia	Normocytic normochromic anaemia
Referral reason in autism	Language delay
Adult outcome of conduct disorder	Antisocial personality disorder
Commonest anxiety disorder (UK NPMS)	Mixed anxiety & depression, then GAD

Topic	Most Common
Commonest anxiety (ECA)	Phobic disorder, then OCD, then panic
Homicide method (commonest)	Sharp instrument (40%); victim usually acquaintance (42%)
EPSE most resistant to treatment	Akathisia
Commonest catatonic sign	Mannerisms (Abrams & Taylor), then stereotypes, stupor, negativism
Commonest symptom of late paraphrenia	Persecutory delusions (~90%); auditory hallucinations ~75%
Commonest cause of late-onset psychosis	Alzheimer's disease
Commonest levodopa psychiatric side effect	Nightmares & vivid dreams (~30%)
Crime in autism spectrum disorder	Arson/fire-setting (most prevalent offence among convicted ASD individuals)
Teratogenic window in pregnancy	Weeks 6-10 (most vulnerable period for major malformations)
Psychiatric disorder in elderly women (community)	Phobias (most common); phobic disorder also most common neurotic condition in the elderly
Diagnosis in prison populations	Personality disorder, especially antisocial PD
Diagnosis among homicide offenders	Personality disorder (psychiatric problem overall: alcohol/drug dependence, then PD)
Defence mechanism in narcissistic PD	Rationalisation
Comorbid depression in vascular dementia	~40-50% of cases (most common comorbidity)
Cause of young-onset dementia (30-64)	Alzheimer's, then vascular, then frontotemporal
Symptom in panic disorder	Palpitations

Topic	Most Common
Comorbidity with hypochondriasis	Generalised anxiety disorder (~71%)
Benzodiazepine withdrawal symptom	Anxiety (then insomnia, excitability, irritability)
Substance abused by adolescents	Alcohol (~30% of 13-year-olds use weekly)
PD in primary care	Cluster C / anankastic (obsessive-compulsive) type
Drug for Lewy body dementia psychosis	Rivastigmine
Behavioural symptom in Alzheimer's	Apathy (~60%) and depression (~58%); commonest psychotic symptom is delusions
Disorder in deliberate self-harm	Depression (90% of hospital DSH have a mental disorder)
Imaging in herpes simplex encephalitis	MRI (most sensitive for early lesions)
SSRI side effect (psychiatric settings)	Sexual dysfunction (~60% of patients)
Inherited cause of learning disability	Fragile X; environmental: fetal alcohol syndrome; overall commonest known cause: Down syndrome
Side effect of rivastigmine	Nausea (also vomiting, diarrhoea, dizziness, anorexia)
Comorbidity of autism in children	ADHD
Early complaint in progressive supranuclear palsy	Unsteadiness of gait and unexplained falls (retropulsion)
Sexual disorder in men	Premature ejaculation (disorder of orgasmic function)
Behavioural phenotype in Prader-Willi	Hyperphagia/increased appetite and skin-picking
Cause of mild and major NCD	Alzheimer's disease

Topic	Most Common
HLA allele in narcolepsy with cataplexy	HLA-DQB1*0602 (CSF orexin markedly reduced)
Psychiatric disorder in HIV	Depression (also most common cause of psychiatric hospitalisation post-HAART; mania most frequent cause overall in some series)
Risk factor for dissociative disorders	History of trauma, especially childhood maltreatment
Reason to seek treatment in separation anxiety	School refusal (esp. adolescents)
Blood picture in adolescent anorexia	Normocytic normochromic anaemia
Reason for referral in autism	Language delay
Adult outcome of conduct disorder	Antisocial personality disorder
Anxiety disorder by survey	ECA: phobic disorder; NPMS: mixed anxiety-depression; NCS-R: specific phobia
Method of homicide	Sharp instrument (~40%); victim usually an acquaintance (~42%)
EPSE most resistant to treatment	Akathisia
Catatonic sign (Abrams & Taylor)	Mannerisms (then stereotypies, stupor, negativism, automatism, echopraxia)
Symptom of late paraphrenia	Persecutory delusions (~90%); auditory hallucinations ~75%; commonest cause of late-onset psychosis is Alzheimer's
Side effect of levodopa	Nightmares/vivid dreams (~30%), then night terrors, delirium, delusions
Disorder after head injury	Post-concussional syndrome (commonest); depression commonest sequela

Topic	Most Common
Cause of Kluver-Bucy in humans	Herpes simplex encephalitis (bilateral temporal damage)
Behaviour change in Huntington's	Lack of initiative, then poor judgement, blunted affect; personality change & depression
Diagnosis associated with suicide	Depression (~30-31%), then alcohol dependence (~17-24%)
Assessment tool in forensic PD	PCL-R (Hare Psychopathy Checklist-Revised)
Delusion among stalkers	Erotomantic (love), then jealousy and persecution
Diagnosis in arsonists	Personality disorder
Offence in learning disability	Offences against property; conduct disorder -> shoplifting
Psychiatric side effect of cyproterone acetate	Depression
Bullying type	General name-calling
Medically unexplained symptom in children	Recurrent headaches, then abdominal pain
Neurobiological finding in autism	Raised blood serotonin (30-50% of children)
Symptom in late-onset schizophrenia	Paranoid (partition) delusions, then auditory hallucinations; negative symptoms absent
Form of elder mistreatment	Neglect (then financial, physical, psychological); perpetrators usually partners/family
Non-hereditary cause of birth defects	Fetal alcohol syndrome
Intracranial complication of cocaine	Non-haemorrhagic infarct; commonest comorbidity: alcohol use disorder
Psychiatric feature of hyperthyroidism	Major depression

Topic	Most Common
Psychiatric feature of hypothyroidism	Cognitive disturbance (delirium most severe; depression second)
Frontotemporal dementia subtype	Motor-neuron type (ubiquitin+, tau-) most frequent
Intracranial opportunistic infection in HIV	Toxoplasmosis
Primary site in metastatic brain cancer	Lung
Lithium toxicity in neonate	Floppy baby syndrome (cyanosis, hypotonicity)
Postpartum mood disturbance	Postpartum blues ('baby blues')
Side effect of aripiprazole	Akathisia (~13%)
Gender-affirming surgery	Top (chest) surgery, most common for trans men and women

NOTE In Wernicke's encephalopathy the single most common sign is confusion (~80%), NOT the classic triad - which appears in only ~10% of cases - so treat on suspicion.

NOTE Several 'most common cause' facts cluster around dementia: Alzheimer's is the commonest cause of young-onset dementia, of late-onset psychosis, and of mild/major neurocognitive disorder overall.

NOTE Learning-disability causes have a classic three-way split: Fragile X (commonest INHERITED), fetal alcohol syndrome (commonest ENVIRONMENTAL), and Down syndrome (commonest OVERALL, though sporadic, not inherited).

NOTE Anxiety-disorder frequency depends on the survey: phobic disorder leads in the ECA study, while mixed anxiety-depression leads in the UK National Psychiatric Morbidity Survey - know which survey is being quoted.

MOST COMMON COMORBIDITY (COMPREHENSIVE)

The single most common comorbidity for each disorder - the source file was blank; this builds the essential set as a key reference.

Commonest Comorbidity by Disorder

Disorder	Most Common Comorbidity
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Disorder	Most Common Comorbidity
OCD	Major depression (commonest); also other anxiety disorders, tics
Hypochondriasis	GAD (71%), then dysthymia, depression
Autism (children)	ADHD (commonest), then anxiety, intellectual disability, epilepsy
ADHD	ODD/conduct disorder (commonest), then anxiety, mood, tics, learning disorder
Bipolar (children)	ADHD (~70%)
Separation anxiety	School refusal; other anxiety disorders
Body dysmorphic disorder	Major depression (commonest), OCD, social anxiety
Tourette's syndrome	OCD and ADHD
Anorexia/bulimia	Depression, anxiety/OCD, substance misuse, personality disorder
Alcohol dependence	Depression, anxiety, antisocial PD
Social anxiety disorder	Other anxiety disorders, depression, alcohol misuse
Dissociative identity disorder	Borderline personality disorder (up to 70%)
Conduct disorder	ADHD; later antisocial personality disorder
PTSD	Depression, other anxiety disorders, substance misuse

NOTE Two recur in exams: major depression is the commonest comorbidity of OCD and body dysmorphic disorder, while ADHD is the commonest comorbidity of childhood autism.

NOTE Dissociative identity disorder has a striking association with borderline personality disorder, present in up to 70% of cases.

PERSONALITY DISORDER ASSOCIATIONS (COMPREHENSIVE)

Personality disorders associated with particular conditions and situations - capturing the full source set with additions.

Personality - Condition Associations

Condition	Associated Personality Disorder
Kleptomania	Paranoid (~50%), then histrionic personality
Factitious disorder	Histrionic, borderline, antisocial personality
Old age (general)	Obsessive-compulsive (anankastic) personality
Somatic symptom disorders	OCPD, avoidant, paranoid personality
Bipolar II	Antisocial, histrionic, borderline (comorbid or misidentified)
Suicide in old age	Anankastic and anxious personality
Paraphrenia	Paranoid personality
Elderly sexual offenders	Schizoid personality
Alcohol	Antisocial behaviour heritability overlaps
Dissociative identity disorder	Borderline personality (up to 70%); also OCPD associated
Gender dysphoria	Borderline personality (association)

NOTE Anankastic (obsessive-compulsive) personality recurs in old-age associations - it is the personality disorder most linked to suicide in older people and prominent in late life generally.

NOTE Borderline personality disorder is the dominant comorbidity of dissociative identity disorder (up to 70%) and is also associated with gender dysphoria and bipolar II.

PHYSICAL & COGNITIVE EXAMINATION (COMPREHENSIVE)

The physical examination of the older patient with dementia, and the structured cognitive examination - capturing the full source set with additions. A core old-age-psychiatry clinical reference.

Physical Examination Signs

Sign	Significance
Temperature (low-reading thermometer)	Detect hypothermia (e.g. in chronic alcoholism, infection-related delirium)
Hydration	If clouding of consciousness suspected (delirium)
Hemiparesis	Suggests large-vessel infarct (vascular dementia)

Sign	Significance
Parkinsonism	Suggests dementia with Lewy bodies
Pseudobulbar palsy	HIV-associated dementia, PSP, vascular dementia, Parkinson's disease
Tremors / involuntary movements	Cerebrovascular event, Huntington's, Wilson's, or levodopa (Parkinson's)
Gait abnormality	Chronic alcoholism, DLB, NPH, MS, PD dementia, tertiary syphilis, vascular dementia
Myoclonus	HIV-associated dementia and Creutzfeldt-Jakob disease
Primitive (frontal release) reflexes	Frontotemporal dementia - palmomental, grasp, pout, sucking, glabellar tap
Visual / hearing impairment	Contributory to confusion & (Charles Bonnet) hallucinations

NOTE Frontal release (primitive) reflexes - grasp, pout, palmomental, glabellar tap - point to frontotemporal dementia; myoclonus suggests CJD or HIV-associated dementia.

Cognitive Examination

Domain	How Assessed
Orientation	Time, place, and person
Attention & concentration	Serial sevens or months of the year backward
Immediate memory	Digit span
Short-term verbal memory	Name & address (6 parts) immediate then at 5 min; Babcock sentence
Short-term nonverbal memory	Recall of a geometric shape after 5 min with distraction
Long-term memory	Date & place of birth (during history)
General knowledge	Current prime minister/monarch, capital cities, flag colours

Domain	How Assessed
Verbal fluency	Words beginning with a letter, or four-legged animals, in 1 min
Praxis	Draw a square/clock (constructional apraxia); fold paper into envelope
Gnosis	Object, picture, tactile, and face recognition
Perseveration	Suggests frontal lobe dysfunction
Other	Calculation, writing, naming (nominal dysphasia), abstraction, judgement

NOTE Constructional apraxia (failure to copy a square or draw a clock) and perseveration are quick bedside markers of parietal and frontal dysfunction respectively.

MECHANISMS OF DISEASE (COMPREHENSIVE)

The pathophysiological mechanisms behind key psychiatric syndromes and drug effects - capturing the full source set with additions. A key mechanism reference.

Disease Mechanisms

Condition	Mechanism
Delirium	Systemic illness → inflammation, oxidative stress, stress hormones; ↓ ACh & melatonin, ↑ dopamine/glutamate/noradrenaline; reticular activating system dysfunction (ACh-mediated) → fluctuating consciousness; anticholinergics worsen it
Valproate hyperammonaemic encephalopathy	Propionate (valproate metabolite) reduces hepatic N-acetylglutamate (activator of CPS-1, the first urea-cycle enzyme); also ↓ hepatic carnitine
Refeeding syndrome	Switch from fat to carbohydrate energy → insulin release → cellular uptake of glucose, phosphate, potassium, magnesium, water → hypophosphataemia → ATP deficit with neuromuscular/haematological consequences

Condition	Mechanism
Alcohol-related blackouts	Alcohol blocks consolidation of new memories via action on medial temporal structures (hippocampus)
MAOI hypertensive crisis	Irreversible gut MAO inhibition allows tyramine absorption → central displacement of noradrenaline → sudden BP rise; prevented by avoiding aged cheeses
Lithium tremor/toxicity	Interference with intracellular signalling (inositol depletion, GSK-3, PKC); narrow therapeutic index
Neuroleptic malignant syndrome	Central dopamine (D2) blockade → hyperthermia, rigidity, autonomic instability
Serotonin syndrome	Excess stimulation of 5-HT2A (and 5-HT1A) receptors
Tardive dyskinesia	Chronic D2 blockade → dopamine receptor up-regulation/supersensitivity
Wernicke's encephalopathy	Thiamine (B1) deficiency → impaired glucose metabolism in vulnerable periventricular regions

NOTE Delirium's core mechanism is reduced acetylcholine disrupting the reticular activating system - which is why anticholinergic drugs precipitate or worsen it.

NOTE Refeeding syndrome hinges on a carbohydrate load triggering insulin-driven cellular uptake of phosphate (and K⁺/Mg²⁺), causing the dangerous hypophosphataemia and ATP depletion.

LEAST COMMON / LOWEST (COMPREHENSIVE)

'Least common', 'lowest', and 'least associated' facts across psychiatry - the mirror image of the most-common compilation. Capturing the source set with additions.

Least Common / Lowest

Topic	Least Common / Lowest
Antidepressants with LEAST sexual side effects	Mirtazapine, bupropion, vortioxetine (also agomelatine, moclobemide)
Least common anxiety disorder in elderly	Panic disorder

Topic	Least Common / Lowest
Lowest lifetime prevalence anxiety disorder	Agoraphobia (~2.5%)
Antipsychotic with lowest EPSE	Clozapine (then quetiapine)
Antipsychotics with least weight gain	Aripiprazole, ziprasidone, lurasidone
Antipsychotic with least prolactin elevation	Aripiprazole (partial agonist)
Mood stabiliser with least teratogenicity	Lamotrigine (lower than valproate/carbamazepine)
Least sedating SSRI	Fluoxetine, sertraline (more activating)
Rarest psychiatric presentation post-stroke	Mania and psychosis (depression & anxiety far commoner)

NOTE Mirtazapine, bupropion, and vortioxetine carry the LEAST sexual dysfunction - the antidepressants to choose (or switch to) when sexual side effects are problematic.

NOTE Agoraphobia has the lowest lifetime prevalence among the anxiety disorders (~2.5%), and panic disorder is the least common anxiety disorder in the elderly.

LOW SERUM IRON (COMPREHENSIVE)

Conditions associated with low serum iron / ferritin in psychiatry - capturing the full source set with additions.

Conditions with Low Serum Iron

Condition	Note
Restless legs syndrome	Low ferritin/iron is a key reversible cause - check ferritin (<50-75 mug/L treat); iron supplementation helps
Periodic limb movement disorder	Associated with low iron stores
Neuroleptic malignant syndrome	Low serum iron is a supportive marker (sensitive in acute NMS)

Condition	Note
Malignant catatonia	Low serum iron reported (overlaps with NMS)
Akathisia	Some association with low iron stores
ADHD	Low ferritin linked to symptom severity in some studies
Pica	Iron-deficiency anaemia both cause and consequence

NOTE Low ferritin is a key REVERSIBLE cause of restless legs syndrome and periodic limb movement disorder - always check iron stores and supplement if ferritin is low.

NOTE Low serum iron is also a supportive marker in neuroleptic malignant syndrome and malignant catatonia, which share overlapping features.

THERAPEUTIC & TOXIC LEVELS (COMPREHENSIVE)

Therapeutic and toxic plasma concentrations of psychotropic drugs requiring monitoring (TDM) - capturing the full source set with corrections. Confirm reference ranges with your local laboratory.

Therapeutic vs Toxic Levels

Medication	Therapeutic Level	Toxic Level
Lithium - acute	0.8-1.2 mEq/L	> 1.5 mEq/L
Lithium - maintenance	0.6-1.0 mEq/L	> 1.5 mEq/L
Valproic acid	50-125 microg/mL (mania)	> 175 microg/mL
Carbamazepine	8-12 microg/mL	> 12 microg/mL
Imipramine	125-250 ng/mL	> 500 ng/mL (or > 1 g)
Desipramine	125-250 ng/mL	> 500 ng/mL (or > 1 g)
Doxepin	100-275 ng/mL	> 500 ng/mL
Amitriptyline	75-225 ng/mL	> 500 ng/mL
Nortriptyline	50-150 ng/mL ('window')	> 500 ng/mL
Clozapine	350-550 ng/mL (optimal); ≥ 350 target	> 1000 ng/mL (seizure risk)

Medication	Therapeutic Level	Toxic Level
Phenytoin	10-20 microg/mL	> 20 microg/mL
Phenobarbital	15-40 microg/mL	> 40 microg/mL

NOTE Lithium's narrow therapeutic index is the classic example: acute 0.8-1.2 and maintenance 0.6-1.2 mEq/L, with toxicity above 1.5 mEq/L.

NOTE Nortriptyline has a therapeutic 'window' (50-150 ng/mL) - efficacy falls at levels both below AND above the range; clozapine above ~350 ng/mL predicts response, with seizure risk above ~1000.

SEROTONIN RECEPTORS & RECEPTOR PHARMACOLOGY (COMPREHENSIVE)

The serotonin (5-HT) receptor family with agonist/antagonist effects, the dopamine pathways, and the clinical effects of receptor blockade - merging both source files into one comprehensive neuropharmacology reference.

5-HT Receptor Subtypes (Agonist / Antagonist Effects)

Receptor	Location	Effects
5-HT1A	Autoreceptor & postsynaptic	Agonist: decrease depression, decrease anxiety (partial agonist), decrease craving/emesis/aggression, increase analgesia, thermoregulation, decrease pos/neg/cognitive symptoms, increase prefrontal dopamine, neuroprotective; direct agonists have poor antidepressant activity
5-HT1B	Cranial vessels, bone	Decrease aggression, vasoconstriction, decrease appetite/anxiety/bone mass, controls sexual behaviour, antidepressant-like
5-HT1C	(Reclassified)	Reclassified as 5-HT2C based on structure & function
5-HT1D (alpha/beta)	Cranial vessels	Vasoconstriction, antimigraine; neurogenic inflammation; speculative role in depression/anxiety
5-HT1E / 1F	CNS	1E unknown; 1F: visual & cognitive function, role in migraine
5-HT2A	Cortex, platelets	Agonist hallucinogenic; antagonist antidepressant/anxiolytic/antipsychotic; potentiates SSRIs; density INCREASED in suicide

Receptor	Location	Effects
5-HT2B	Cardiac valves	Antidepressant effect; cardiovascular (agonist increases pulmonary hypertension & valvular fibrosis)
5-HT2C	Choroid plexus, appetite	Antidepressant & anxiolytic & anorexic; decreases impulsivity & drug/food motivation
5-HT3	Gut, area postrema	Antagonist antiemetic (incl. chemo), decreases GI side effects & anxiety; antidepressant-like; increases cognition; controls dopamine; suppresses withdrawal effects (alcohol/cocaine/nicotine)
5-HT4	Gut, CNS	Antidepressant & rapid anxiolytic; improves cognition; reduces feeding (prokinetic)
5-HT5A	CNS	Unknown; possible role in depression, anxiety, locomotion, learning, memory
5-HT6	Limbic/cortex	Antidepressant-like; cognitive enhancement, memory & learning (dementia target)
5-HT7	Hypothalamus, thalamus	Regulates circadian rhythm; antidepressant-like; pro-cognitive; analgesia

NOTE 5-HT2A is the pivotal psychiatric serotonin receptor: agonism is hallucinogenic, antagonism is antipsychotic/antidepressant and potentiates SSRIs, and its density is **INCREASED** in suicide victims.

NOTE 5-HT1A partial agonism (buspirone) is anxiolytic and antidepressant, but **DIRECT** 5-HT1A agonists have poor antidepressant activity on their own.

Dopamine Pathways (effect of D2 blockade)

Pathway	Effect of Low Dopamine / D2 Blockade
Nigrostriatal	Low dopamine (D2 blockade) -> extrapyramidal side effects: dystonia, akathisia, parkinsonism, dyskinesia
Mesolimbic	Low dopamine -> desirable antipsychotic effect (controls POSITIVE symptoms of psychosis)
Mesocortical	Low dopamine -> NEGATIVE symptoms (alogia, anhedonia, amotivation, apathy)
Tuberoinfundibular	Low dopamine -> raised prolactin: irregular periods, infertility, erectile dysfunction, osteoporosis, gynaecomastia

Pathway	Effect of Low Dopamine / D2 Blockade
Incertohypothalamic	Low dopamine -> disturbed thermoregulation and possibly weight gain

NOTE The four classic dopamine tracts explain antipsychotic effects and side effects: mesolimbic blockade is therapeutic (positive symptoms), while nigrostriatal blockade causes EPSEs, mesocortical worsens negative symptoms, and tuberoinfundibular raises prolactin.

Mirtazapine & 5-HT2 Antagonism

Topic	Note
Mirtazapine 5-HT2 & 5-HT3 blockade	5-HT3 antagonism = low nausea + antiemetic; 5-HT2 antagonism = anxiolytic & antidepressant
5-HT2 antagonists	Trazodone, mirtazapine, olanzapine, quetiapine are potent 5-HT2 antagonists
5-HT2 in depression	Increased 5-HT2 binding density in post-mortem depressed/suicidal patients
Antidepressants vs ECT (5-HT2)	Long-term antidepressants REDUCE 5-HT2 & increase 5-HT1A function; ECT INCREASES 5-HT2A

NOTE Mirtazapine's 5-HT3 antagonism explains its low nausea, while its 5-HT2 blockade (shared with trazodone, olanzapine, quetiapine) contributes to its anxiolytic and antidepressant effects.

Other Receptor Pharmacology & Blockade

Receptor / Class	Clinical Effects
Dopamine agonists	Common (dose-dependent): nausea, vomiting, orthostatic hypotension, headache, dizziness, arrhythmia. Long-term: choreiform/dystonic movements, hallucinations, delusions, confusion, depression, mania, impulse-control disorders (hypersexuality, gambling, shopping, hyperphagia)
Anticholinergic (muscarinic) blockade	Central: seizures, pyrexia, reduced cognition. Peripheral: blurred vision, urinary retention, constipation (esp. clozapine), sinus tachycardia, amnesia, dry mouth. Caution in glaucoma & prostatism

Receptor / Class	Clinical Effects
Cholinergic agonists	CNS: miosis, blurred vision, headache, dizziness, drowsiness. CV: bradycardia, heart block, hypotension, arrest. GI: nausea, vomiting, cramps, diarrhoea, salivation, involuntary defecation. GU: urinary urgency. Other: flushing, sweating
Alpha-adrenergic blockade	Dose-dependent postural hypotension, dizziness, syncope, tachycardia, ejaculatory failure/impotence
Histaminergic (H1) blockade	Sedation, weight gain, possible anti-emetic effect (chemoreceptor trigger zone)
Cardiotoxic effects	QT prolongation, ST elevation, heart block, arrhythmias

NOTE Dopamine agonists (used in Parkinson's/RLS) classically cause impulse-control disorders - hypersexuality, pathological gambling, compulsive shopping, and hyperphagia - especially with long-term use.

NOTE Receptor-blockade side effects map predictably: muscarinic (dry mouth, retention, blurred vision), alpha-adrenergic (postural hypotension), histaminergic (sedation, weight gain), plus class cardiotoxicity (QT prolongation).

RATING SCALES & ASSESSMENT TOOLS (COMPREHENSIVE)

A comprehensive reference to psychiatric rating scales and assessment instruments, grouped by domain, with what each measures and its defining features - capturing the full source set with additions. one of the most important exam topics.

Depression Scales

Scale	Use / Key Features
HAM-D (Hamilton Depression)	Clinician-rated; 17 or 21 items; 17-item max 52-54, score >24 = severe; the standard clinician depression scale
MADRS (Montgomery-Asberg)	Clinician-rated; 10 items; MOST sensitive to change among depression scales
Beck Depression Inventory (BDI)	Self-rated; 21 items (0-3 each); 0-13 minimal, 14-19 mild, 20-28 moderate, 29-63 severe; revised 1966
Zung Self-Rating Depression Scale	Self-rated; 20 items (1-4 each)

Scale	Use / Key Features
Geriatric Depression Scale (GDS)	Self-rated; 30 items (yes/no); 0-9 normal, 10-19 mild, 20-30 severe; for the elderly
Edinburgh Postnatal Depression Scale (EPDS)	Perinatal screen at 6-8 weeks; item 10 flags self-harm; measures depression/anxiety/anhedonia; validated in pregnancy & general population
Cornell Scale for Depression in Dementia	For depression in dementia; combines carer interview (20 min) + patient interview (10 min)
Depressive Sign Scale	9 items; detects depression in people with dementia
BASDEC	Brief Assessment Schedule Depression Cards; 'true/false' cards for elderly inpatients (usable even if deaf); score ≥ 7 suggests depression

NOTE Core depression-scale facts: HAM-D (17 items, max 52-54, >24 severe) is the clinician standard, MADRS (10 items) is most sensitive to change, and BDI (21 items) is the classic self-report; the GDS (30 items) is the elderly screen.

Psychosis, Mania, Anxiety & OCD

Scale	Use / Key Features
PANSS	Schizophrenia symptom severity; 7 positive + 7 negative + 16 general items ('seven-seven-sixteen'); each on 7-point scale; uses interview + staff/family reports of prior week
BPRS (Brief Psychiatric Rating Scale)	Probably the most widely used scale; ≥ 18 items, Likert-rated; psychotic AND affective symptoms (not motor side effects)
Young Mania Rating Scale (YMRS)	Clinician-rated; 11 items; mania severity in bipolar disorder
HAM-A (Hamilton Anxiety)	Clinician-rated; 14 items; anxiety severity
Panic Disorder Severity Scale (PDSS)	Clinician-rated; panic frequency/intensity, anticipatory anxiety, avoidance, work & relationship impairment

Scale	Use / Key Features
Y-BOCS	Scale of choice for OCD; clinician semi-structured; rates obsessions & compulsions separately (time/distress/impairment/resistance/control) on 4-point scale; rates hoarding; does NOT measure anankastic/perfectionist traits
GAF / CGI / DESS	GAF (global functioning, DSM-IV axis V, /100); CGI (clinician-rated illness severity); DESS (43-item antidepressant discontinuation symptoms)

NOTE PANSS structure is a classic exam point: 7 positive + 7 negative + 16 general psychopathology items ('seven, seven, sixteen'), each on a 7-point scale, drawing on interview plus staff and family reports.

NOTE The Y-BOCS is the scale of choice for OCD and rates hoarding, but specifically does NOT measure anankastic (obsessive-compulsive personality) perfectionist traits - a frequently tested distinction.

Movement / Extrapyrimal Scales

Scale	Use / Key Features
Simpson-Angus Scale	Drug-induced parkinsonism/EPSE; easy to administer in trials
Barnes Akathisia Rating Scale	Assesses akathisia specifically
AIMS	Abnormal Involuntary Movement Scale - tardive dyskinesia
Bush-Francis Catatonia Rating Scale	Rates catatonic features
UPDRS (Unified Parkinson's Disease Rating Scale)	Parkinson's DISEASE (NOT drug-induced parkinsonism)

NOTE Match the movement scale: Simpson-Angus (parkinsonism), Barnes (akathisia), AIMS (tardive dyskinesia), Bush-Francis (catatonia). UPDRS is for Parkinson's DISEASE, not drug-induced parkinsonism.

Cognitive & Delirium

Scale	Use / Key Features
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Scale	Use / Key Features
MMSE	Most widely used bedside screen; emphasises dominant-hemisphere functions; less sensitive to change than ADAS-Cog; poor for Down syndrome dementia
MoCA / ACE-R (Addenbrooke's)	More sensitive cognitive screens
Other cognitive screens	CDR, GPCOG, 6-CIT, 7-Minute Screen; CAMCOG (part of CAMDEX)
ADAS-Cog	De facto standard primary outcome in dementia drug trials; 0-70; 4-point change at 6 months = clinically important; MMSE less sensitive
Hachinski Ischaemic Score	Differentiates vascular dementia from Alzheimer's; score >6 indicates vascular dementia (items: abrupt onset, fluctuating/stepwise course, strokes, focal signs, hypertension, etc.)
CAMDEX / CAMDEX-R	Cambridge Examination for Mental Disorders; structured interview + neuropsychology + informant interview + DSM-IV/ICD-10 criteria; incorporates MMSE, Hachinski, NART
Confusion Assessment Method (CAM)	Delirium diagnosis; sensitivity 94-100%, specificity 90-95%; ~5-10 min; reduced sensitivity if used by nurses vs physicians
Delirium Rating Scale (DRS)	Most widely used delirium scale; distinguishes delirium from dementia; needs skilled clinician
Cognitive Test for Delirium (CTD)	For patients with impaired communication (intubated/immobile)
IQCODE	Informant Questionnaire on Cognitive Decline in the Elderly
GMSS	Geriatric Mental State Schedule; broad psychopathology in older people; ~45 min; community surveys

Scale	Use / Key Features
Neuropsychiatric Inventory (NPI)	Records behavioural & psychological symptoms of dementia (BPSD)

NOTE *Hachinski Ischaemic Score >6 points to vascular rather than Alzheimer's dementia; ADAS-Cog (not MMSE) is the standard primary outcome in dementia drug trials, with a 4-point change at 6 months considered clinically important.*

NOTE *The Confusion Assessment Method (CAM) gives a rapid delirium diagnosis (sensitivity 94-100%), while the Delirium Rating Scale is the most widely used and distinguishes delirium from dementia.*

Forensic, Personality & Capacity

Scale	Use / Key Features
HCR-20	Structured violence-risk tool; 10 Historical + 5 Clinical + 5 Risk-management items; good inter-rater reliability; predicts inpatient & community violence
PCL-R (Hare)	Psychopathy; 20 items scored 0-2 (range 0-40); cut-off 25 to diagnose psychopathy
Static-99	10-item actuarial tool for adult male sexual offenders (>=18 yr at release)
IPDE	International Personality Disorder Examination; semi-structured interview (DSM-IV & ICD-10); 7 domains (work, self, affects, relationships, reality testing, impulse control, behaviour before 15)
SAPAS	Standardised Assessment of Personality - Abbreviated Scale; 8 items, ~2 min; score >=3 warrants further assessment
Other PD scales	FFMRF (30 items, self-report); PDQ-R (100 true/false); IPDS (11 criteria, <5 min); IIP-PD (127 items)
EPQ (Eysenck Personality Questionnaire)	Self-rated; 106 items; dimensions E (extraversion), N (neuroticism), P (psychoticism)
MacCAT-T	MacArthur Competence Assessment Tool; capacity to consent to treatment; 20-25 min; 4 areas: understanding, appreciation, reasoning, expressing a choice

NOTE Forensic trio: HCR-20 (violence risk, 10+5+5 items), PCL-R (psychopathy, cut-off 25), and Static-99 (actuarial risk in adult male sexual offenders); the MacCAT-T assesses capacity across four areas.

Child, Alcohol & Substance

Scale	Use / Key Features
Denver Developmental Screening Test	Screens developmental delay birth-6.5 yr (personal/language/motor/social); screening tool only
WISC / WAIS	Wechsler scales - WISC for children (<16; verbal/performance/full-scale IQ), WAIS for adults
Strengths & Difficulties Questionnaire (SDQ)	Emotional/conduct/hyperactivity/peer/prosocial domains; obtains school information
CAFAS	Child & Adolescent Functional Assessment Scale; impairment from emotional/behavioural problems; aggression & conduct; ages 7-17; ~10 min
AUDIT	10 items; score ≥ 8 harmful/hazardous; ≥ 13 women / ≥ 15 men indicates dependence
CAGE / DAST	Brief alcohol screen / Drug Abuse Screening Test
SAWS	Short Alcohol Withdrawal Scale; self-completion (prior 24 h); score >12 needs pharmacotherapy
SBIRT	Screening, Brief Intervention, Referral to Treatment; uses AUDIT/DAST; effective for risky alcohol use (not moderate-severe AUD)

NOTE AUDIT thresholds: ≥ 8 indicates harmful/hazardous drinking, while ≥ 13 in women and ≥ 15 in men indicates dependence; Wechsler splits by age (WISC <16, WAIS adults).

Sleep, QoL & Specialist Scales

Scale	Use / Key Features
Epworth Sleepiness Scale	Daytime sleepiness; cut-off >11 (men) / >9 (women)
Multiple Sleep Latency Test (MSLT)	Objective sleepiness/narcolepsy; 20-min naps x4-5; latency 0-5 min = severe, 5-10 troublesome, 10-15 manageable, 15-20 mild

Scale	Use / Key Features
SF-36	Generic health-related quality-of-life measure (physical/social/mental)
Clinical Interview Schedule-Revised (CIS-R)	Fully structured interview for minor psychiatric morbidity in community; usable by trained lay interviewers
Judgment of Line Orientation Test	Detects RIGHT-hemisphere disease (matching lines of same slope)
AEC tool	Anticholinergic Effect on Cognition; 'traffic-light' system scoring drugs 0-3 (0 = none, 3 = most)
DMR / PAS-ADD	Dementia Questionnaire for Mentally Retarded Persons (Down/intellectual disability screening); PAS-ADD for psychiatric disorder in learning disability (29 items, 5 scales)

NOTE On the MSLT, a mean sleep latency of 0-5 minutes indicates severe sleepiness; the Judgment of Line Orientation test specifically detects right-hemisphere dysfunction.

LANDMARK STUDIES & TRIALS (COMPREHENSIVE)

Landmark psychiatric studies and clinical trials, grouped by field, with design and key findings - capturing the full source set with additions. Among a key exam topics.

Schizophrenia & Psychosis

Study	Design & Findings
ECA (1980-85)	5 US sites, ~20,000; any disorder lifetime 32.3%; substance 16.4%, anxiety 14.6%, affective 8.3%, schizophrenia 1.5%; DIS detected only ~20% of psychiatrist-diagnosed schizophrenia
CATIE (2005)	1493 patients; olanzapine/perphenazine/quetiapine/risperidone/ziprasidone; ~70-75% discontinued by 18 mo (quetiapine highest 82%, olanzapine lowest 64%); olanzapine most effective but most weight gain; perphenazine comparable; clozapine best in phase 2 efficacy pathway; MetS ~41% (F 51.6%, M 36%)

Study	Design & Findings
CUtLASS (2006)	UK - no clear advantage of second- over first-generation antipsychotics in quality of life/symptoms
IPSS (WHO 1973)	9 centres; narrow (Schneiderian) schizophrenia similar incidence across cultures; outcome better in developing countries
DOSMeD (Sartorius 1986)	Extended IPSS to rural/healers/police/prisons; catatonia commoner & acute onset more frequent in developing world; hebephrenia 13% (developed) vs 4% (developing); better outcome partly from family tolerance
AESOP (2006)	UK 3-centre first-presentation; schizophrenia ~9x African-Caribbean, ~6x Black African vs White British; more compulsory admission & criminal-justice referral; migration strongest risk factor

NOTE CATIE's headlines: ~70-75% discontinued within 18 months, olanzapine marginally most effective but most weight gain, perphenazine (old & cheap) comparable, and clozapine supreme in the phase-2 efficacy pathway.

NOTE The WHO cross-cultural studies (IPSS, DOSMeD) found schizophrenia had a **BETTER** outcome in developing countries, attributed partly to family tolerance - with catatonia commoner and hebephrenia rarer there.

Depression & Bipolar

Study	Design & Findings
STAR*D	Pragmatic, 4 steps (citalopram → switch/augment → mirtazapine/nortriptyline+lithium/T3 → MAOI/venlafaxine+mirtazapine); ~⅓ remit at step 1; ~⅓ never remit; switching SSRI = switching class; add-on 1 in 3 improve
TADS	Adolescent depression; combination (CBT+fluoxetine) 71% > fluoxetine 61% > CBT 43% ~ placebo 35%; combination fastest recovery
TORDIA	Treatment-resistant adolescent depression; benefit from adding atypical antipsychotic or lithium
SADHART	Sertraline safe after MI; greater effect in severe/recurrent depression

Study	Design & Findings
MIND-IT	Antidepressants did NOT alter post-MI depression course or cardiac outcome
STEP-BD	Bipolar; biggest relapse predictor = residual symptoms; most relapses into depression
BRIDGE	~Half of 'unipolar' depression presentations later show bipolarity (underdiagnosis)

NOTE STAR*D: ~⅓ remit on the first antidepressant, ~⅓ remain resistant after four steps, and switching SSRI is no worse than switching class.

Child, Addiction & Epidemiology

Study	Design & Findings
POTS I	Paediatric OCD; combination (CBT+sertraline) remission 53.6% > CBT 39.3% > sertraline 21.4% > placebo 3.6%; start CBT ± SSRI
Project MATCH	9-centre US alcohol RCT (1726); CBT vs TSF vs MET broadly equal; little benefit from matching; readiness-to-change & self-efficacy strongest predictors; TSF better for low psychiatric severity & drinking-supportive networks
UKATT	UK alcohol RCT (742); novel Social Behaviour & Network Therapy not significantly different from MET
Cambridge Study in Delinquent Development (Farrington)	411 South London males age 8-32; predictors of delinquency: antisocial behaviour, hyperactivity-impulsivity, low IQ/attainment, family criminality, poverty, poor parenting
WMH Survey	28 countries, >154,000; US highest prevalence; anxiety most common then mood; wide variation
UK National Psychiatric Morbidity Survey (2000)	>10,000 (CIS-R); 1 in 6 neurotic disorder; commonest mixed anxiety-depression (88/1000) then GAD (44/1000); 5/1000 psychotic; commonest PD anankastic
UK700	Intensive case management of psychotic patients similar in cost to standard care

Study	Design & Findings
Isle of Wight study (Rutter)	Landmark child epidemiology; prevalence & reading retardation

NOTE Project MATCH's surprise: matching patients to therapies gave little benefit - CBT, 12-step facilitation, and motivational enhancement were broadly equal, with readiness-to-change the strongest predictor.

RISK FACTORS (COMPREHENSIVE)

Risk and vulnerability factors across psychiatric disorders, forensic situations, and drug reactions - capturing the full source set with additions. A core formulation and exam reference.

Risk Factors by Disorder/Situation

Disorder / Situation	Risk Factors
PTSD	Female, younger/older, low SES, single/divorced, unemployed, low education & social support, family history, previous/childhood trauma, severity of exposure, negative appraisal, pre-existing psychopathology, external locus of control, peritraumatic distress & dissociation
Alzheimer's disease	Ageing, MCI, genetic mutations/ApoE e4, family history, female, low education, head injury, type II diabetes
Alzheimer's in Down syndrome	Age & ApoE e4 (most established); family history, maternal age, female, atypical karyotype, lower cognitive reserve
Autism	Genetic loading (STRONGEST); intellectual impairment, Fragile X, Rett, valproate, maternal gestational diabetes/bleeding, breech, low Apgar, <35 weeks, parental psychiatric history; NO link to SES/parental age/weight-for-gestation
Child abuse - parent	Single/young parent, abused as a child, low self-esteem, unrealistic expectations, punishment-oriented discipline, substance misuse, low IQ, criminal record
Child abuse - environment	Social isolation, current stress, large family, domestic violence, poverty, dangerous neighbourhood

Disorder / Situation	Risk Factors
Child abuse - child factors	Prematurity, congenital malformation, intellectual disability, chronic illness, difficult (crying) temperament, younger age, disability
Conduct problems (vulnerability)	Parental mental illness/substance misuse, young maltreated mother (<18), parents in residential care, parental criminal-justice involvement
Post-head-injury delirium	Old age, severe medical comorbidity, polypharmacy, basal-ganglia & right-hemisphere lesions
Dissociative amnesia/fugue	Childhood trauma (esp. sexual abuse), repeated/interpersonal trauma, combat, high-severity trauma, mild TBI
Clozapine neutropenia	Afro-Caribbean (+77%), younger age, low baseline WCC
Clozapine agranulocytosis	Increasing age, Asian ethnicity (~2.4x) - DIFFERENT profile from neutropenia
Suicide in MS	Male, young age at onset, current/past depression, social isolation, substance misuse
Anorexia nervosa	Premature birth, small-for-gestational-age, cephalhaematoma, physical illness, perfectionism, family history
Restless legs syndrome	Older age, female, pregnancy, iron deficiency/anaemia, renal failure, hypothyroidism, diabetes, B12 deficiency
Perimenopausal depression	History of depression (incl. postpartum/premenstrual), vasomotor symptoms, sleep difficulty, chronic illness, losses, psychosocial problems
Postpartum depression	Antenatal depression/anxiety, personal & family history, previous PPD, stressful events, poor social/partner support, low self-esteem, raised placental CRH
Depression in Parkinson's	Female, younger onset, right-sided signs, bradykinesia/gait disturbance, rapid progression, poorer cognition & ADLs

NOTE Genetic loading is the single strongest risk factor for autism; age plus ApoE e4 are the most established for Alzheimer's (and for Alzheimer's in Down syndrome).

NOTE Clozapine neutropenia and agranulocytosis have DIFFERENT risk profiles: neutropenia rises in Afro-Caribbean and younger patients, agranulocytosis with older age and Asian ethnicity.

SUICIDE RATES (COMPREHENSIVE)

Suicide rates and relative risks by disorder, distinguishing (where possible) completed suicide from attempts - capturing the full source set with additions. Figures vary between studies.

Suicide Rates by Disorder

Disorder	Suicide Rate / Relative Risk
Schizophrenia	~5-6% die by suicide (lifetime from onset 5.6%); ~20% attempt; ~10x general population
Bipolar disorder	~10-19% (most-cited 30% in older/untreated; range 15-50%); 15x general population; >=25% attempt; ~80% of attempts in depressed phase
Affective psychosis	~15%
Alcoholism / alcohol dependence	~15% (lifetime)
Major depressive disorder	Attempts higher in women; completions higher in men
Borderline personality disorder	~9-10%
Antisocial personality disorder	~5%
Body dysmorphic disorder	~20% attempt (NOT 50%)
Pathological gambling	~17-24%
Multiple sclerosis	~30% of deaths in some series; 2-7.5x general population
Epilepsy	5-10x general population (~10% in some series)
Temporal lobe epilepsy	~25x general population
Huntington's disease	4-6x (up to 12.7%; ~7% in some series); ideation in carriers ~20%; 3rd commonest cause of death
Cushing's syndrome	~3-10%

Disorder	Suicide Rate / Relative Risk
Over-65s	~20% of all completed suicides occur in this group
Dementia & intellectual disability	NOT raised - the exceptions (raised in ALL other disorders)
SSRI in children	Spontaneously-reported suicidal ideation/behaviour ~1-3 per 100

NOTE The schizophrenia figure was revised from the long-quoted ~10% to ~5.6% when measured from first admission/onset (Palmer 2005) - know both.

NOTE Completed suicide is raised in ALL psychiatric disorders EXCEPT intellectual disability and dementia - a frequently tested exception. In depression, attempts are commoner in women but completions in men.

PEAK AGE OF ONSET (COMPREHENSIVE)

Peak ages (and bimodal peaks) of onset across psychiatric disorders and events - capturing the full source set with additions.

Peak Age of Onset

Disorder / Event	Peak Age
Bipolar disorder	Men 15-19, women 20-24 (~5-yr gap); community onset 15-19, hospital mean 21
Anorexia nervosa	15-19 years
ADHD	3-8 years
Selective mutism	6-10 years
Stammering	~5 years
School refusal	Three peaks: ~5 (separation anxiety), ~11 (school transition), 14-16 (depression/social phobia)
Sexual abuse (victim)	Average 9-11 years
Head injury	15-24 years
Agoraphobia	First peak 15-35, second 45-54

Disorder / Event	Peak Age
Panic disorder	Two peaks: larger ~15-25, later 45-54
Anxiety (women)	Peak 4th-5th decades; men constant through adult life
Pain disorder	4th-5th decades
Chronic fatigue syndrome	Mean 29-35 years
Sporadic CJD	~67 years
Lesch-Nyhan (self-injury)	Mean 3.5 years
Arson	Men ~17, women ~45 (80% convicted are men)
Self-harm in learning disability	15-20 years, male predominance
Postnatal depression	Within 6 months (peak 3-4 weeks)
Homicide offenders (women)	>40% aged 30-39

NOTE Panic disorder and agoraphobia each peak around 15-25 and again at 45-54 years; school refusal has three peaks (~5, ~11, 14-16) mapped to developmental transitions.

NOTE Arson shows a striking sex-age split: men peak ~17 and women ~45 years.

AGE THRESHOLDS FOR DIAGNOSIS (COMPREHENSIVE)

Age criteria embedded in diagnoses - the maximum age by which symptoms must appear, or the minimum age before a diagnosis can be made. Capturing the full source set with additions.

Diagnostic Age Thresholds

Disorder	Age Criterion
ADHD	Several symptoms before age 12
Childhood disintegrative disorder	Onset before age 10 (after ≥ 2 yr normal development)
Conduct disorder (childhood-onset)	≥ 1 symptom before age 10
Conduct disorder (general)	Before age 18
Tourette's / tic disorder	Onset before age 18

Disorder	Age Criterion
Transient tic disorder	Tics nearly every day ≥ 4 weeks but < 12 consecutive months
Feeding disorder of infancy/early childhood	Before age 6
Global developmental delay	Diagnosis under age 5
Intellectual disability	Before age 18 (developmental period)
Intermittent explosive disorder	Cannot be diagnosed before age 6
Developmental coordination disorder	Cannot be diagnosed before age 5
Written expression disorder	Usually identified after age 8
Dissociative identity disorder	Begins in childhood, usually diagnosed in late 20s

NOTE Onset-BEFORE thresholds: ADHD before 12, childhood-onset conduct disorder before 10, intellectual disability and Tourette's before 18.

NOTE Minimum-age (cannot-diagnose-before) thresholds: intermittent explosive disorder before 6, developmental coordination disorder before 5 - the mirror image.

SLEEP ARCHITECTURE CHANGES (COMPREHENSIVE)

Characteristic sleep-architecture (polysomnographic) changes across psychiatric disorders and with key drugs - capturing the full source set with additions.

Sleep Changes by Condition / Drug

Condition / Drug	Sleep Changes
Depression	Short REM latency, increased REM amount & density, prolonged sleep latency, frequent waking, low arousal threshold, reduced slow-wave sleep, delta shifted to 2nd NREM cycle
Mania / hypomania	Short REM latency, inability to fall asleep, short sleep duration, reduced delta sleep
PTSD	More Stage 1, less slow-wave sleep (shallower); nightmares

Condition / Drug	Sleep Changes
Elderly	Increased sleep latency/awakenings/Stage 1-2, decreased Stage 3-4 & REM & REM latency, reduced efficiency & total sleep, phase-advance ('morningness')
Alcohol	Decreased sleep latency initially then fragmentation; reduced REM & slow-wave; worsens obstructive sleep apnoea (reduced upper-airway tone)
Borderline PD	Shortened REM latency, disturbed maintenance, abnormal DST/TRH (depression-like)
Melatonin	Shortens sleep & REM latency, fewer interruptions, increased total sleep
Benzodiazepines	Increase N2 (Stage 2), suppress N3 (slow-wave); reduce REM & delta
GABA agonists (alcohol, BZD, barbiturates)	Reduce REM and delta sleep
SSRIs / SNRIs (NA, 5-HT, histamine)	Suppress REM sleep

NOTE The signature of depression is *SHORT REM latency with increased REM density and reduced slow-wave sleep* - the most consistently examined sleep finding.

NOTE GABA-ergic drugs (alcohol, benzodiazepines, barbiturates) suppress *BOTH REM and slow-wave sleep*; benzodiazepines specifically increase Stage 2 (N2) while suppressing N3.

SOCIAL CLASS & PSYCHIATRIC DISORDERS (COMPREHENSIVE)

Associations between social class / urban-rural setting and psychiatric disorders - capturing the full source set with additions.

Higher Social Class / SES

Disorder	Association
Anorexia nervosa	Higher SES & Western Caucasian; private schools 1% (vs state 0.15%); ballet/modelling ~7%; greater parental education
Vaginismus	Highly educated women & higher SES

Disorder	Association
Bipolar disorder	Traditionally slightly higher classes
Completed suicide	Raised in BOTH upper and lower classes (bimodal)

NOTE Anorexia nervosa is the classic higher-SES disorder - strikingly elevated in ballet/modelling schools (~7%) versus state schools (~0.15%).

Lower Social Class / SES

Disorder	Association
Schizophrenia	Over-represented in lower classes (social drift vs causation); urban birth 2x risk
Anxiety disorders	Greater at lower SES & education
Separation anxiety disorder	50-75% from low-SES homes
Somatization disorder	Rural, non-white, unmarried, less-educated
PTSD	Low SES a risk factor
Learning disability (subcultural)	Mild/subcultural type concentrated in class V; biological type evenly distributed
ADHD	Social deprivation & institutional care (3x boys)
Chronic fatigue syndrome	Lower occupational status & education
Cognitive impairment in Parkinson's	Low SES & education
Non-fatal DSH	Lower social class
Violence in mental illness / homicide-suicide	Lower SES (with male sex, young age)
Peptic ulcer / development	Lower SES
Placebo response	More likely in lower social class

NOTE Schizophrenia's over-representation in lower classes fuels the social-drift versus social-causation debate (evidence favours drift); completed suicide is unusual in being raised at BOTH class extremes.

Urban vs Rural

Disorder	Setting
Schizophrenia	Urban birth ~2x rural
Depression / AD	More common in urban settings
Personality disorders	Higher in urban populations
Somatization disorder	Relatively more common rural
Conduct disorder	Urban living does NOT clearly increase rates
Alcohol (Finnish twins)	Similar rural/urban rates, but genetic influence greater urban, environmental greater rural

NOTE Urban birth roughly doubles schizophrenia risk; the Finnish twin studies showed genetic influence on adolescent drinking is greater in urban and environmental influence greater in rural settings.

DSM SPECIFIERS (COMPREHENSIVE)

Diagnostic specifiers and subtypes used to qualify DSM diagnoses - course, severity, and feature specifiers - capturing the full source set with additions.

Specifiers by Disorder

Disorder	Specifiers
Autism spectrum disorder	With/without intellectual impairment; with/without language impairment; associated medical/genetic/environmental factor; associated with another disorder; with catatonia
Delusional disorder	Erotomantic, grandiose, jealous, persecutory, somatic, mixed, unspecified; with bizarre content; course specifiers after 1 year
Brief psychotic disorder	With marked stressor(s) (brief reactive psychosis); without; with postpartum onset (≤ 4 weeks); with catatonia
Schizophreniform disorder	With good prognostic features (≥ 2 of: onset within 4 weeks, confusion/perplexity, good premorbid function, no flat affect); without; with catatonia

Disorder	Specifiers
Schizophrenia / schizoaffective	Course specifiers (first/multiple episode; acute/partial/full remission; continuous; unspecified) after 1 year; with catatonia
Persistent depressive disorder (dysthymia)	With pure dysthymic syndrome; with persistent major depressive episode; with intermittent major depressive episodes (with/without current episode)
Psychotic disorder due to medical condition	With delusions; with hallucinations
Narcolepsy	Without cataplexy but hypocretin deficiency; with cataplexy but no deficiency; AD cerebellar ataxia-deafness-narcolepsy; AD narcolepsy-obesity-diabetes; secondary; severity mild/moderate/severe
Nightmare disorder	Severity (mild <1/wk; moderate ≥1/wk; severe nightly); course (acute ≤1 mo; subacute 1-6 mo; persistent ≥6 mo)
Enuresis	Nocturnal only; diurnal only; nocturnal and diurnal
Encopresis	With constipation & overflow incontinence; without
Erectile dysfunction	Situational vs generalised; lifelong vs acquired; partner/relationship/individual/cultural/medical factors
Substance-induced disorders	With onset during intoxication; during withdrawal; after medication use
Autism spectrum disorder	With/without intellectual impairment; with/without language impairment; associated with a known medical/genetic/environmental factor; associated with another neurodevelopmental/mental/behavioural disorder; with catatonia
Brief psychotic disorder	With/without marked stressor(s) (brief reactive psychosis); with postpartum onset (≤4 weeks); with catatonia

Disorder	Specifiers
Schizophreniform disorder	With good prognostic features (≥ 2 of: onset < 4 weeks, confusion/perplexity, good premorbid function, no blunted/flat affect); without good prognostic features; with catatonia
Substance/medication-induced psychotic disorder	With onset during intoxication; with onset during withdrawal; with onset after medication use
Psychotic disorder due to another medical condition	With delusions (predominant); with hallucinations (predominant)
Other specified schizophrenia spectrum	Persistent auditory hallucinations; delusions with overlapping mood episodes; attenuated psychosis syndrome; delusional symptoms in partner of an individual with delusional disorder
Persistent depressive disorder (dysthymia)	With pure dysthymic syndrome; with persistent major depressive episode; with intermittent MDEs (with or without current episode)
Substance-induced anxiety disorder	With onset during intoxication; with onset during withdrawal; with onset after medication use
Erectile dysfunction	Situational vs generalised; lifelong vs acquired; with partner/relationship/individual-vulnerability/cultural/medical factors
Narcolepsy	Without cataplexy but with hypocretin deficiency; with cataplexy but without hypocretin deficiency; autosomal-dominant variants; secondary to another condition; severity: mild/moderate/severe
Nightmare disorder	Severity: mild (< 1 /week) / moderate / severe (nightly); course: acute (≤ 1 mo), subacute (1-6 mo), persistent (≥ 6 mo)
Encopresis	With constipation and overflow incontinence; without constipation and overflow incontinence
Enuresis	Nocturnal only; diurnal only; nocturnal and diurnal

NOTE 'With catatonia' recurs as a cross-cutting specifier across ASD and the psychotic disorders (brief psychotic, schizophreniform, schizophrenia, schizoaffective) and mood disorders.

NOTE Schizophreniform 'good prognostic features' need ≥ 2 of four: onset of psychosis within 4 weeks of a behavioural change, confusion/perplexity, good premorbid function, and absence of blunted/flat affect.

NOTE 'With catatonia' is shared across the psychotic disorders (schizophrenia, schizophreniform, brief psychotic, schizoaffective) and applies to mood disorders too - a recurring cross-cutting specifier.

NOTE Schizophreniform 'good prognostic features' needs ≥ 2 of: psychosis onset within 4 weeks of behavioural change, confusion/perplexity, good premorbid function, and absence of flat affect.

TRIADS & TETRADS

Classic diagnostic triads and tetrads in psychiatry and neurology, with memory aids. A favourite rapid-recall exam format.

Diagnostic Triads & Tetrads

Condition	Triad / Tetrad
Normal pressure hydrocephalus	DUG: Dementia, Urinary incontinence, Gait apraxia (gait is 1st, most prominent, and improves with treatment)
Wernicke's encephalopathy	CAO: Confusion, Ataxia, Ocular abnormality (nystagmus, 6th-nerve palsy, gaze paresis)
Korsakoff's syndrome	RAC: Retrograde amnesia, Anterograde amnesia, Confabulation
Parkinson's disease	TRB: Tremor, Rigidity, Bradykinesia
Limbic encephalitis	ATP: Anterograde amnesia, Temporal-lobe epilepsy, Psychiatric symptoms
Charcot's neurologic triad (MS)	Nystagmus, intention tremor, scanning (staccato) speech
Meningitis	Fever, neck stiffness, altered mental state
Cushing's (psychiatric)	Depression, anxiety, hypomania (mood lability)
Serotonin syndrome	Neuromuscular (clonus/hyperreflexia), autonomic instability, altered mental state
Neuroleptic malignant syndrome (tetrad)	Hyperthermia, rigidity, autonomic instability, altered consciousness (+ raised CK)

Condition	Triad / Tetrad
Lithium toxicity (early)	Coarse tremor, ataxia, dysarthria (+ GI upset)
Delirium tremens	Clouding of consciousness, vivid hallucinations, marked tremor (+ autonomic arousal)
Tuberous sclerosis	ELF: Epilepsy, Learning disability, Facial skin lesions (adenoma sebaceum)
Narcolepsy (tetrad)	Sleep attacks/hypersomnia (100%), Cataplexy (90%), Sleep paralysis (40%), Hypnagogic/hypnopompic hallucinations (30%)
Dementia with Lewy bodies (tetrad)	Parkinsonism, Neuroleptic sensitivity, Visual hallucinations, Fluctuating cognition/dementia
Creutzfeldt-Jakob disease (tetrad)	Dementia, Myoclonus, Distinctive periodic EEG complexes, Pyramidal & extrapyramidal signs
Phenylketonuria	Eczema, Epilepsy, Vomiting (untreated: learning disability, fair hair/skin, musty odour)
Beck's cognitive triad	Negative views of the Self, the World, and the Future (depression)
Acute intermittent porphyria	Acute abdominal pain, Polyneuropathy, Psychosis
Pellagra (4 D's)	Dementia, Diarrhoea, Dermatitis, Death (niacin/B3 deficiency)
Kernberg's object relations	Self-representation, Object-representation, Affect linking the two
Dark Tetrad	Psychopathy, Narcissism, Sadism, Machiavellianism
Anton's syndrome	Denial of visual disability, Confabulation of visual content, Occipital lesion (cortical blindness)
Triangle of insight	Transference, Current relationships, Past relationships
Charcot-Wilbrand syndrome	Visual agnosia, Loss of ability to revisualize, Impaired dream imagery
Balint's syndrome	Simultanagnosia, Ocular apraxia, Optic ataxia (bilateral parieto-occipital)

Condition	Triad / Tetrad
Kluver-Bucy syndrome (tetrad)	Placidity/loss of fear, Hyperorality, Hypersexuality, Hypermetamorphosis (psychic blindness)
Kleine-Levin syndrome	Hypersomnia, Hypersexuality, Hyperphagia, Abnormal behaviour (irritability/aggression)
Ganser's syndrome	Approximate answers (Vorbeigehen), clouding of consciousness, somatic conversion, pseudo-hallucinations
Korsakoff (mnemonic RAC)	Retrograde amnesia, Anterograde amnesia, Confabulation

NOTE Narcolepsy's classic tetrad in descending frequency: sleep attacks (~100%) > cataplexy (~90%) > sleep paralysis (~40%) > hypnagogic/hypnopompic hallucinations (~30%).

NOTE Kluver-Bucy syndrome (placidity, hyperorality, hypersexuality, hypermetamorphosis) follows bilateral temporal-lobe damage - in humans most often from herpes simplex encephalitis.

NOTE Memorise the mnemonics: NPH = 'DUG' (Dementia, Urinary incontinence, Gait apraxia); Wernicke = 'CAO' (Confusion, Ataxia, Ocular signs); Korsakoff = 'RAC' (Retrograde + Anterograde amnesia, Confabulation).

NOTE In normal pressure hydrocephalus, the gait disturbance appears **FIRST**, is the most prominent feature, and is the one most likely to improve after shunting — a frequently tested clinical point.

PRODROMAL SYMPTOMS (COMPREHENSIVE)

Prodromal (and premorbid) symptoms preceding the full onset of psychiatric and neuropsychiatric disorders - capturing the full source set with additions.

Prodromal Features

Disorder	Prodromal / Premorbid Symptoms
Schizophrenia	Social withdrawal, deteriorating function, odd ideas/perceptions, reduced concentration, attenuated psychotic symptoms (at-risk mental state)
Early-onset schizophrenia (premorbid)	Delays in language, reading, bladder control, social functioning; deficits in attention, working memory, premorbid IQ (genetic/developmental marker)

Disorder	Prodromal / Premorbid Symptoms
Tourette's syndrome	Irritability, hyperactivity, inattention, poor frustration tolerance precede tics
Prion disease / CJD	Fatigue, anxiety, appetite/sleep problems, poor concentration; brief prodrome of anxiety, depression, or hallucinations
Huntington's disease	Personality change, antisocial behaviour with substance misuse, affective & schizophreniform disorders
Delirium	Restlessness, fearfulness, irritability, sleep disturbance, transient disorientation
Delirium tremens	Tremor, anxiety, autonomic arousal, perceptual disturbance before full DTs
Migraine	Aura, mood change, food cravings, yawning hours before headache
Mood / bipolar episode	Sleep change, irritability, mood instability heralding an episode

NOTE The schizophrenia prodrome (social withdrawal, declining function, attenuated psychotic symptoms) defines the 'at-risk mental state' targeted by early-intervention services.

NOTE In Tourette's, a behavioural prodrome of irritability, hyperactivity, inattention, and poor frustration tolerance often PRECEDES the motor and vocal tics.

PROTECTIVE FACTORS (COMPREHENSIVE)

Factors that REDUCE risk or confer a better prognosis across disorders and forensic outcomes - capturing the full source set with additions.

Protective Factors

Outcome	Protective Factors
Child abuse (against)	Parental resilience, social connections, knowledge of parenting/child development, concrete support in need, social-emotional competence of the child

Outcome	Protective Factors
Reoffending (reduced)	First time in custody, employment in prior 12 months, worry about imprisonment, older age, longer sentences (>1 yr)
Alzheimer's disease (against)	Bilingualism, cognitive engagement, late retirement, fish >1x/week, high education (>15 yr), physical activity >3x/week, NSAID & statin use
Conduct disorder (better prognosis)	Female gender, high IQ, resilient temperament, good parenting
Suicide (protective)	Strong social support, religious belief, responsibility for children, help-seeking, reasons for living, therapeutic alliance
Resilience (general)	Secure attachment, easy temperament, problem-solving skills, at least one supportive adult, community connectedness

NOTE Alzheimer's protective factors form a 'cognitive reserve' theme: education, bilingualism, cognitive engagement, physical activity, and fish intake - plus NSAID and statin use in some studies.

NOTE In conduct disorder, female gender, high IQ, resilient temperament, and good parenting predict a better outcome - the mirror image of its risk factors.

PSYCHIATRIC MANIFESTATIONS OF MEDICAL DISEASE (COMPREHENSIVE)

Psychiatric presentations of endocrine, metabolic, neurological, and systemic medical conditions - capturing the full source set with additions. The essential 'organic differential'.

Medical Disease -> Psychiatric Presentation

Medical Condition	Psychiatric Manifestation
Hyperthyroidism	GAD, depression, hypomania, irritability
Severe thyrotoxicosis	Mania
Hypothyroidism	Depression, cognitive dysfunction
Subclinical hypothyroidism	Depression, rapid cycling
Myxoedema madness	Psychosis
Addison's disease	Depression, apathy, anhedonia

Medical Condition	Psychiatric Manifestation
Cushing's disease	Depression, anxiety, hypomania
Exogenous (steroid) Cushing's	Mania
Hyperparathyroidism (mild / severe)	Mild: depression, apathy; Severe: delirium, catatonia
Hypoparathyroidism (mild / severe)	Mild: anxiety; Severe: psychosis, mania
Acromegaly	Depression, mood lability, personality change
Phaeochromocytoma	Anxiety / panic-like episodes
Hyperprolactinaemia	Depression
Polycystic ovarian syndrome	Social phobia, depression
Diabetes mellitus	Depression (~2x risk)
Neurosyphilis (GPI)	Depression, grandiosity, dementia, personality change
Multiple sclerosis	Lifetime depression ~50%; euphoria; pseudobulbar affect
Epilepsy	Personality change (hyper/hyposexuality, religiosity) - commonest neuropsychiatric presentation
Prenatal alcohol exposure	ADHD (most predominant diagnosis)
Symptomatic hypokalaemia / acute metabolic acidosis	Depression / delirium
Chronic metabolic acidosis	Depression
Crohn's disease / dialysis	Crohn's: anxiety; dialysis: psychosis & mood lability

NOTE Thyroid disease spans the mood spectrum: hyperthyroidism -> anxiety/irritability (severe -> mania), hypothyroidism -> depression/cognitive slowing (severe -> 'myxoedema madness' psychosis).

NOTE Steroid effects depend on source: endogenous Cushing's tends toward depression/anxiety, whereas EXOGENOUS steroids classically cause mania.

SUBSTANCE KEYWORDS & SIGNS (COMPREHENSIVE)

Characteristic clinical signs and 'buzzwords' pointing to specific substances of misuse - capturing the full source set with additions.

Substance Spot-Diagnosis Signs

Substance	Characteristic Sign(s)
Ketamine	Severe ulcerative cystitis, frank haematuria, urinary frequency/urgency/dysuria (up to ~30% of chronic users)
MDMA	Increased friendliness, empathy, desire for mental activity; calming (not anxiety)
Phencyclidine (PCP)	Horizontal AND vertical nystagmus; peripheral analgesia/diminished pain response; violence
LSD	Colourful (vivid) visual hallucinations
Cannabis	Injected (red) conjunctivae
Cocaine	Atrophy/perforation of nasal mucosa/septum
Mephedrone ('meow-meow')	'Fishy' smell in sweat, runny nose
Severe lithium toxicity	Downbeat nystagmus
Opioids	Pinpoint pupils, respiratory depression, constipation
Amphetamines / stimulants	Dilated pupils, bruxism, formication ('cocaine bugs')
Substances causing dementia (DSM)	Alcohol, inhalants, sedatives, hypnotics, anxiolytics

NOTE Nystagmus direction helps localise the toxin: vertical AND horizontal nystagmus -> phencyclidine (PCP); downbeat nystagmus -> severe lithium toxicity.

NOTE Chronic ketamine use causes a distinctive ulcerative cystitis with haematuria and urinary urgency in up to ~30% of users - a key, easily forgotten complication.

SYMPTOM -> BRAIN AREA (COMPREHENSIVE)

Localisation of psychiatric symptoms and functions to brain regions and circuits - the functional neuroanatomy of psychopathology. Capturing the source with additions.

Symptom / Function -> Neuroanatomy

Symptom / Function	Brain Area / Circuit
Psychomotor retardation (depression)	Decreased blood flow to caudate nucleus / dorsolateral prefrontal cortex
Panic disorder	Temporal lobe (hippocampus); parahippocampal & amygdala dysfunction
OCD	Hyperactivity of orbitofrontal cortex-caudate-thalamus loop
Depression (mood)	Decreased left dorsolateral prefrontal cortex; subgenual cingulate overactivity
Schizophrenia (negative symptoms)	Hypofrontality (decreased dorsolateral prefrontal activity)
Auditory hallucinations	Activation of primary auditory cortex / Broca's area
Wernicke-Korsakoff	Mammillary bodies, dorsomedial thalamus
Kluver-Bucy syndrome	Bilateral amygdala / anterior temporal lobes
Procedural memory	Basal ganglia & cerebellum
Declarative memory	Hippocampus & medial temporal lobe
Fear conditioning	Amygdala
Aggression / placidity	Amygdala & hypothalamus
Utilisation behaviour / disinhibition	Frontal lobes (orbitofrontal)

NOTE OCD localises to a hyperactive orbitofrontal-caudate-thalamic loop - the circuit normalised by SSRIs, CBT, and (in refractory cases) cingulotomy.

NOTE Two memory systems contrast cleanly: declarative memory depends on the hippocampus/medial temporal lobe, while procedural memory depends on the basal ganglia and cerebellum.

TYPES & SUBTYPES (COMPREHENSIVE)

Classifications and subtypes across psychiatric disorders - the named 'types' that recur in single-best-answer questions. Capturing the full source set with additions.

Types & Subtypes

Disorder	Types / Subtypes
Erectile dysfunction - ICD types	1: full erection early then declines before ejaculation; 2: erection only when intercourse not considered; 3: partial erection insufficient for intercourse; 4: no tumescence at all
Erectile dysfunction - DSM	Acquired vs lifelong; situational vs generalised
Delusional disorder types	Erotomantic, grandiose, jealous, persecutory, somatic, mixed, unspecified
Delirium types	Hyperactive, hypoactive (worst prognosis), mixed
Bipolar types	I (mania), II (hypomania + depression), cyclothymia, rapid-cycling
Korsakoff confabulation types	Provoked (momentary) vs spontaneous (fantastic)
Attachment types	Secure, anxious-avoidant, anxious-resistant/ambivalent, disorganised
Conduct disorder types (DSM)	Childhood-onset (<10) vs adolescent-onset
Conduct disorder subtypes (ICD)	Socialised, unsocialised, family-confined, oppositional defiant
Firesetting motivations	Pyromania (tension relief), revenge, vandalism, concealment of crime, political

NOTE Erectile dysfunction has a detailed ICD typology (four patterns by when the erection fails) alongside the simpler DSM split into lifelong/acquired and situational/generalised.

NOTE Hypoactive delirium (quiet, withdrawn) carries the WORST prognosis and is most often missed - despite hyperactive delirium being more noticeable.

CLINICAL RULES & RULES OF THUMB (COMPREHENSIVE)

Memorable clinical rules and heuristics across psychiatry - capturing the full source set with additions. Use as prompts, not rigid prescriptions.

Clinical Rules

Rule	Detail
Bipolar 'rule of 3'	Clues to bipolarity: 3 marriages before 30, failure of 3 antidepressants, 3 careers by 30, 3 first-degree relatives with mood disorder, 3 consecutive affected generations
Valproate loading (inpatient)	Rough rule: weight in pounds x 10 = approximate initial daily loading dose in mg
Dementia prevalence rule	Rises exponentially, roughly DOUBLING every 5 years of age
Cannabis-psychosis age rule	Younger first use = higher risk; ~4.5x schizophrenia risk if regular use at 15 vs ~1.65x if first use at 18 (Murray 2004)
Anxiety-disorder sex rule	All anxiety disorders commoner in women EXCEPT: OCD (commoner in boys; equal in adults) and social phobia (men outnumber women attending services)
Lithium therapeutic rule	Maintain 0.6-1.0 mmol/L; toxicity > 1.5; check level 12 h post-dose
Goodman's antidepressant rule (children)	SSRI-related suicidal ideation/behaviour ~1-3 per 100 children treated
ECT seizure-duration rule	Aim for adequate generalised seizure (~15-120 s); too short -> augment/hyperventilate

NOTE The bipolar 'rule of 3' (3 failed antidepressants, 3 marriages, 3 careers, 3 affected relatives, 3 affected generations) prompts reassessment for an underlying bipolar diathesis.

NOTE The anxiety sex-ratio rule has two exceptions: OCD (commoner in boys, equal in adults) and social phobia (men outnumber women in clinical attendance).

DIFFERENTIAL COMPARISONS (V.S.)

A comprehensive side-by-side reference distinguishing commonly confused diagnoses and concepts across psychiatry — the discriminating features that separate look-alike conditions. one of the most important formats for differential-diagnosis and single-best-answer questions.

Mood & Bipolar Spectrum

Comparison	Distinguishing Features
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Comparison	Distinguishing Features
Bipolar vs Borderline PD	Bipolar: onset early 20s, mood changes spontaneous (not purely event-driven), self-harm linked to depression, self-mutilation rare. Borderline: cycles much faster (several times/day), mood reactive to events, distinct swings (fear/sadness/anger/love each up-down), uses 'emptiness' as descriptor, self-mutilation common
Bipolar depression vs Unipolar depression	Bipolar: family history of bipolar, psychomotor agitation, psychotic depression in early adulthood; episodes more rapid in onset, more frequent, more severe, SHORTER, reverse neurovegetative (hyperphagia, hypersomnia). Unipolar: more anxiety, insomnia, somatic complaints
Bipolar II vs Bipolar I	II 'milder' only in mania severity (hypomania < mania). II spends MORE time depressed (mood symptoms 54% vs 47%; depressive 93% vs 67%), greater chronicity, more lifetime episodes, higher suicidality & poorer functional recovery; inter-episode interval shortens with age
Bipolar vs ADHD	Bipolar: affects MOOD, episodic/cycling with clear onset-offset, euphoria/psychosis/↓need for sleep, hypersexuality, grandiosity. ADHD: affects behaviour/attention, CHRONIC (non-episodic), onset < 7–12 yr, no elevated mood/psychosis, does not itself cause sleeplessness
BAD vs BPD (patient-experience themes, Richardson & Tracy 2015)	Bipolar: more public awareness, diagnosis taken more seriously, seen as genetic/'chemical', medication-oriented, more family support. BPD: greater stigma & staff hopelessness/blame, insidious relationship sabotage, harder to conceal
Late-life mania vs early-onset mania	Late: mixed depressive symptoms, prior depressed phase, may herald frontal dementia, men > women (~60% vs 10% in one series), cerebral organic/vascular association ('secondary mania'), less genetic loading

Comparison	Distinguishing Features
Elderly mania vs young mania	Elderly: garrulousness, slow flight of ideas, more circumstantial/less disorganised speech, more paranoid delusions, less hyperactivity, cognitive impairment, irritable surliness & less euphoria, mixed states, longer/more frequent episodes

NOTE Bipolar II is 'milder' ONLY in the height of its highs — patients spend MORE time depressed than in bipolar I (~93% vs ~67% of symptomatic time), which drives the higher suicidality and chronicity.

NOTE Bipolar vs ADHD hinges on course: bipolar is EPISODIC (cycling mood with clear onset/offset, euphoria, ↓ need for sleep), whereas ADHD is CHRONIC (persistent inattention/hyperactivity without elevated mood or psychosis).

Depression, Grief & Old Age

Comparison	Distinguishing Features
Depression – children vs adolescents	Young children: poor feeding, failure to thrive, tantrums, separation anxiety, regression (enuresis/soiling). Adolescents: somatisation, hypochondriasis, school refusal, declining schoolwork, antisocial behaviour, substance misuse; anhedonia & social withdrawal are powerful indicators
Early-onset vs late-onset depression	Early: episodic-memory deficits, bereavement events commoner. Late: attention/executive (frontal) deficits, more cognitive impairment (~70%), anhedonia, psychomotor change, weight loss; less family history of mood disorder, more dementia development, ventricular enlargement, white-matter hyperintensities
Depression – young vs old (shared & different)	Shared: sleep disturbance, poor appetite, weight loss. More in old: behavioural disturbance, loneliness, hypochondriasis, pseudodementia, irritability, loss of interest replacing low mood, minimisation/denial of mood, paranoid/delusional ideation, somatic preoccupation

Comparison	Distinguishing Features
Depression vs Bereavement	Suggest depression: active suicidal ideation, symptoms 'out of proportion'/prolonged, guilt unrelated to deceased, marked persistent functional impairment & psychomotor change, preoccupation with worthlessness, psychotic symptoms (beyond pseudohallucinations of widowhood)
Grief vs Major depressive episode (DSM)	Grief: emptiness/loss, comes in waves ('pangs') tied to reminders, positive emotions/humour preserved, self-esteem intact, death thoughts about 'joining' the deceased. MDE: persistent depressed mood, pervasive anhedonia, worthlessness/self-loathing, death thoughts about ending one's own life
Pseudodementia vs Dementia	Pseudodementia: past history of depression/identifiable precipitant, relatively abrupt onset, patient COMPLAINS of poor memory, 'don't know' answers, shorter duration. Dementia: insidious, conceals deficits, confabulates/near-miss answers
Depression in learning disability vs general population	Under-detected: cognitive symptoms (memory/concentration), guilt, suicidal thoughts. More readily detected: biological symptoms (psychomotor retardation, sleep/appetite/weight, diurnal variation); agitation, irritability, behavioural disturbance, loss of ADLs, tearfulness may signal hidden depression
Anxiety – elderly vs young	Elderly: anxious preoccupation with illness/finance/crime/family, subjectively impaired sleep (may be normal ageing), somatic symptoms misattributed to physical illness, sedative abuse/overprescription

NOTE Grief vs MDE: grief comes in WAVES tied to reminders with preserved self-esteem and 'joining the deceased' thoughts, whereas MDE brings PERSISTENT low mood, worthlessness/self-loathing, and thoughts of ending one's own life.

NOTE Pseudodementia points to depression: abrupt onset, an identifiable precipitant, the patient COMPLAINING of poor memory, and 'don't know' answers — unlike the concealment and confabulation of true dementia.

Psychosis & Schizophrenia

Comparison	Distinguishing Features
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Comparison	Distinguishing Features
Delusional disorder vs Schizophrenia	Delusional: NON-bizarre delusions (could occur in real life), no functional deterioration, no negative symptoms or loosening; tactile/olfactory hallucinations only within the delusional theme. Schizophrenia: bizarre delusions, deterioration, negative symptoms
Schizoaffective vs mood disorder with psychosis	Schizoaffective: ≥ 2 weeks of delusions/hallucinations WITHOUT a major mood episode. Mood disorder w/ psychosis: psychotic features occur ONLY during mood episodes (in bipolar, always cotemporal)
Depersonalization/derealization vs Psychosis	DPDR: intact reality testing, no frank hallucinations. (DPDR occurs in 11–42% of schizophrenia and becomes incorporated into the delusional system)
Amphetamine/stimulant psychosis vs Schizophrenia	Stimulant: paranoia is hallmark; NO negative symptoms, visual hallucinations predominate, appropriate affect, hyperactivity, sexual disinhibition, confusion/incoherence, almost no formal thought disorder, rapid resolution (days), positive urine screen
Alcohol hallucinosis vs Schizophrenia	Alcohol hallucinosis: atypical/late age of onset, drinking clearly precedes onset, remits with abstinence, lack of thought disorder and affective incongruence
Early-onset schizophrenia (EOS) vs adult schizophrenia	EOS more malignant: greater negative symptoms & cognitive deficits, poorer medication response & prognosis; premorbid language/motor/social delays; deficits in attention, working memory, premorbid IQ
Very-late-onset vs typical schizophrenia	Very-late: less family history, less affective blunting, less formal thought disorder, MORE visual hallucinations, greater tardive-dyskinesia risk, better antipsychotic response & neuropsychological performance, female predominance

Comparison	Distinguishing Features
Late-onset vs young-onset schizophrenia (symptoms)	Late: persecutory & partition delusions commoner. Young: catatonia, thought insertion/withdrawal, negative symptoms (affective blunting), formal thought disorder commoner

NOTE Delusional disorder is set apart from schizophrenia by NON-bizarre delusions, preserved functioning, and absence of negative symptoms or loosening — with hallucinations confined to the delusional theme.

NOTE Stimulant and alcohol-related psychoses share key 'organic' clues: prominent visual hallucinations, preserved affect, lack of formal thought disorder, a temporal link to the substance, and remission with abstinence.

Dementias & Parkinsonism

Comparison	Distinguishing Features
Vascular dementia vs Alzheimer's	AD: insidious onset, continuous course, less insight, fewer affective symptoms, no hypertension/neuro signs. VaD: stepwise, more depression, persecutory delusions, anxiety, emotional disturbance, focal signs
Alzheimer's vs Frontotemporal dementia	FTD: younger onset, severe apathy/disinhibition, reduced speech, loss of insight, social coarsening, primitive reflexes (grasp/pout/palmomental), LESS spatial disorientation. AD: worse calculation/construction, lower MMSE, depression ~20%. Both insidious; Klüver-Bucy can occur in either
DLB vs Parkinson's disease dementia	DLB '1-year rule' (cognition precedes/within 1 yr of motor signs); PDD develops ≥ 1 yr (mean 10, up to 20) after motor onset. DLB: faster decline, more attentional deficits, spontaneous visual hallucinations at any stage, less tremor, more postural/gait instability; up to 25% never develop parkinsonism
Progressive supranuclear palsy vs AD/DLB	PSP: prominent parkinsonism, early gait disturbance & poor balance, brainstem signs (vertical ophthalmoplegia, pseudobulbar palsy)

Comparison	Distinguishing Features
Drug-induced vs neurodegenerative parkinsonism	Drug-induced: BILATERAL tremor, resolves (may take months) after stopping antidopaminergic; DaT (SPECT/PET) imaging NORMAL. Neurodegenerative (PD): usually unilateral/asymmetric resting tremor; ABNORMAL DaT (loss of nigrostriatal dopamine transporter)

NOTE DaT (dopamine-transporter) imaging separates drug-induced parkinsonism (NORMAL scan, bilateral tremor, reversible) from neurodegenerative parkinsonism (ABNORMAL scan, asymmetric resting tremor) — useful early, before clinical features declare themselves.

Child & Developmental

Comparison	Distinguishing Features
School refusal vs Truancy	Refusal: emotional (not antisocial) symptoms, satisfactory academic record, overprotective parents, small family, familial neurosis. Truancy: antisocial, educational underachievement/poor record, inconsistent parents, larger family
Autism vs Asperger's syndrome	Both: male predominance, poor social skills. Autism: poor communication, low IQ common, seizures commoner. Asperger's: fairly developed communication/language, narrow circumscribed interests (severe), IQ mild-LD to normal, seizures uncommon
DMDD vs IED vs Bipolar	DMDD: chronic irritable mood BETWEEN outbursts. IED: outbursts but NORMAL mood between. Paediatric bipolar: discrete EPISODIC mood disturbance (euphoria, grandiosity, racing thoughts, ↓ need for sleep). DMDD differs from ODD by requiring severe irritability
Motor stereotypies vs Tics	Stereotypies: earlier onset (< 3 yr), prolonged (seconds-minutes), constant fixed form/location, worse when engrossed, NO premonitory urge, stop with distraction. Tics: later onset, brief, premonitory urge, suppressible
Deaf children of deaf vs hearing parents	Deaf-of-deaf are better in: maturity, independence, responsibility-taking, impulse control, empathising, and parental expectation-achievement match

NOTE DMDD vs IED vs bipolar turns on the inter-outburst state: chronic irritability between outbursts = DMDD, normal mood between = IED, and discrete episodic mood disturbance = bipolar.

NOTE Motor stereotypies differ from tics by their earlier onset (< 3 yr), fixed prolonged form, absence of a premonitory urge, and cessation on distraction.

Sleep, Substance & Pharmacology

Comparison	Distinguishing Features
Nightmare vs Night terror	Nightmare: REM, last third of night, vivid recall, easily roused, content remembered. Night terror: deep NREM (stage 3–4), first third, inconsolable, autonomic surge, amnesia for the episode
Restless legs syndrome vs Periodic limb movement disorder	RLS: while AWAKE; uncomfortable crawling/tingling with an urge to move for relief. PLMD: during SLEEP; repetitive leg jerks/twitches, often unknown to the sufferer
Modafinil vs Stimulants	Modafinil: lacks euphoria, no dependence/tolerance, does not precipitate psychosis; licensed for narcolepsy, OSA, shift-work; adjunct in depression; used as a 'smart drug'
Buprenorphine vs Methadone	Buprenorphine: better retention than placebo, injectable (abuse liability), more expensive (~5×), preferred with enzyme-inducing/inhibiting drugs (less affected). Methadone: better for heavy heroin users (settle better on high dose)
Mu vs Kappa opioid agonists	Mu (morphine-like): analgesia, respiratory depression, euphoria, drowsiness, constipation; ↑ dopamine in VTA; tolerance to most effects except miosis/constipation. Kappa: dysphoria, no pupillary effect, some analgesia; ↓ dopamine in VTA
Type 1 vs Type 2 alcoholism (Cloninger)	Type 1: milieu-limited (environmental), both sexes, loss of control, weak family history, onset > 25 yr. Type 2: male-limited, paternal inheritance, onset < 25 yr, prominent criminality, poor prognosis

NOTE Cloninger's typology: Type 1 alcoholism is milieu-limited (environmental, both sexes, later onset), while Type 2 is male-limited (paternal inheritance, onset < 25, criminality, poor prognosis).

Neuropsychiatry & Forensic

Comparison	Distinguishing Features
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Comparison	Distinguishing Features
NMS vs Serotonin syndrome	NMS: idiosyncratic reaction to therapeutic neuroleptic; BRADYKINESIA & lead-pipe rigidity. Serotonin syndrome: toxic 5-HT _{2A} overstimulation; HYPERKINESIA, myoclonus, hyperreflexia, clonus
Psychopathy vs Antisocial PD	ASPD ~3–5% population (psychopathy < 1%). ~80% of male prisoners meet ASPD but only ~15% psychopathy; ~81% of psychopaths meet ASPD but only ~35–40% of ASPD are psychopaths. Psychopaths: less impulsive aggression, more INSTRUMENTAL violence, higher serious-violence & recidivism rates
Hyperactive vs Hypoactive delirium	Hyperactive: restlessness, ↑ activity/speed, pressure of speech, aggression — BETTER prognosis. Hypoactive: apathy, listlessness, ↓ speech, hypersomnolence — worse prognosis, often missed. BOTH show diffuse EEG slowing
Facial nerve UMN vs LMN lesion	UMN: contralateral LOWER face affected, upper face SPARED (bilateral forehead innervation) — can wrinkle forehead/close eyes ('central facial weakness'). LMN: BOTH upper & lower face, SAME side (e.g. Bell's palsy)
Subcultural vs Biological learning disability	Subcultural: family with borderline IQ, mild/borderline severity, lower SES (class V), no dysmorphism/syndrome, psychosocial causation. Biological: evenly across classes, dysmorphic & syndromic features, behavioural phenotypes
Dual-role transvestism vs Fetishistic transvestism	Dual-role: cross-dressing WITHOUT sexual motivation, no desire for permanent sex change. Fetishistic: cross-dressing produces sexual arousal (a paraphilia)
Psychogenic vs Organic erectile dysfunction	Psychogenic: sudden onset, early collapse of erection, PRESERVED morning/self-stimulated erections, relationship/life-event trigger. Organic: preserved ejaculation despite impaired erection, intact libido early, vascular risk/injury/drug history

NOTE NMS vs serotonin syndrome is a motor contrast: NMS brings BRADYKINESIA and lead-pipe rigidity, whereas serotonin syndrome brings HYPERKINESIA, clonus, myoclonus, and hyperreflexia.

NOTE Most psychopaths meet antisocial PD criteria, but most people with antisocial PD are NOT psychopaths — psychopathy adds instrumental (planned) violence and markedly higher recidivism.

NOTE UMN facial lesions spare the forehead (bilateral cortical innervation) and affect the contralateral lower face; LMN lesions (e.g. Bell's palsy) weaken the whole ipsilateral half of the face.

Women's Mental Health & Anxiety

Comparison	Distinguishing Features
Dysmenorrhoea vs PMDD	Dysmenorrhoea: painful menses beginning WITH onset of menses. PMDD: affective symptoms beginning BEFORE menses (luteal phase), may linger into first days
Premenstrual syndrome vs PMDD	PMS: no minimum 5-symptom requirement, no mandatory affective symptom, more common, less severe. PMDD: ≥ 5 symptoms with required affective symptom, more severe & impairing
GAD vs non-pathological anxiety	GAD worries are pervasive, excessive, distressing, longer-lasting, often without precipitant, span many life domains, accompanied by physical symptoms, impair functioning. Everyday worry is manageable, deferrable, rarely with physical symptoms
Speaking-only vs Complex social phobia	Speaking-only ('non-generalised'): fear of public speaking. Complex ('generalised'): fear of multiple social situations — more disabling, familial, longer-lasting, lower spontaneous recovery, higher comorbidity

NOTE Timing separates the premenstrual disorders: dysmenorrhoea pain begins WITH menses, whereas PMDD's affective symptoms begin BEFORE menses in the luteal phase; PMS is the milder, less-specified relative of PMDD.

Eating Disorders

Comparison	Distinguishing Features
Depressive disorder vs Anorexia nervosa	Depression: DECREASED appetite, no fear of obesity, no body-image disturbance, agitation unplanned. Anorexia: claims NORMAL appetite/hunger ($\downarrow$ only when severe), PLANNED ritualistic hyperactivity, preoccupation with recipes/calories, intense fear of obesity
Somatization disorder vs Anorexia nervosa	Somatization: weight fluctuations/vomiting/odd food-handling possible but LESS weight loss, NO fear of weight gain, amenorrhoea ≥ 3 months unusual. (Both can co-occur — then diagnose both)

Comparison	Distinguishing Features
Schizophrenia vs Anorexia nervosa	Schizophrenia: food delusions usually about poisoning (not calories), no fear of obesity, no anorexic hyperactivity, bizarre eating but not the full syndrome
Anorexia nervosa vs Bulimia nervosa	Anorexia: underweight, restriction, sees self as fat, severe medical sequelae (cardiac, bone, organ). Bulimia: usually normal/fluctuating weight, recurrent binge-purge ($\geq 1 \times / \text{wk} \times 3$ months), electrolyte/dental/GI complications; self-esteem tied to shape/weight

NOTE In anorexia the patient claims a normal appetite with **PLANNED**, ritualistic hyperactivity and calorie preoccupation, whereas depressive anorexia involves genuinely decreased appetite without fear of obesity or body-image disturbance.

INTOXICATION vs WITHDRAWAL (COMPREHENSIVE)

Intoxication and withdrawal features for each major substance, side by side - capturing the full source set with additions. Note which withdrawal states are potentially fatal.

Intoxication vs Withdrawal by Substance

Substance	Intoxication	Withdrawal
Alcohol	Poor concentration, impaired reaction times, CONJUNCTIVAL injection, poor coordination, memory difficulties, impaired judgement & sense of time/space, slurred speech, ataxia, nystagmus	Within 12 h: tremor, diaphoresis, sleeplessness, GI distress, anxiety, craving; peaks 48 h; grand-mal seizures (esp. prior seizures/head injury/hyponatraemia); ~5% DTs (clouded consciousness, Lilliputian hallucinations, agitation, autonomic change) - can be FATAL
Opioids	Initial euphoria then apathy/dysphoria, pupillary CONstriction (dilation = severe overdose/anoxia), drowsiness/coma, slurred speech, inattention, psychomotor change, respiratory depression	'Cold turkey' (rarely fatal): begins 6-8 h, peaks 2 days, eases over a week; dysphoria, nausea/vomiting, muscle aches, lacrimation/rhinorrhoea, pupillary DILATION, piloerection, diarrhoea, yawning, fever, insomnia; craving/insomnia can persist months

Substance	Intoxication	Withdrawal
Cocaine	Euphoria, increased energy/confidence/self-esteem, reduced need for sleep, mydriasis, tachycardia, hypertension, formication; high dose: agitation, impulsive aggression, mania-like, arrhythmia, seizures; nasal septal perforation (sniffing)	Intense CRAVING with striking lack of physical symptoms; dysphoric 'crash', anhedonia, anxiety, irritability, hypersomnolence, fatigue, vivid unpleasant dreams, increased appetite; ends within 18 h (up to a week in heavy users, peaks 3 days)
Amphetamine	Euphoria or affective blunting, hypervigilance, interpersonal sensitivity, anxiety/tension/anger, stereotyped behaviours, dry mouth, hyperthermia, dilated pupils, tachycardia/bradycardia, BP change, agitation/retardation; chest pain, arrhythmia, seizures	Dysphoric 'crash' (+/- suicidal ideation), fatigue, vivid unpleasant dreams, hypersomnia, increased appetite, psychomotor retardation, SMALL pupils
Cannabis	Impaired motor coordination, euphoria, slowed time sense, social withdrawal, CONJUNCTIVAL injection, increased appetite ('munchies'), dry mouth, tachycardia; sometimes heightened perception, depersonalization/derealization; motor impairment outlasts euphoria	Rare (only after high-dose sustained use): irritability, insomnia, anorexia, mild nausea, tremor, anxiety
Benzodiazepines	Slurred speech, incoordination, unsteady gait, nystagmus, impaired attention/memory, stupor/coma, disinhibition (inappropriate sexual/aggressive behaviour), mood lability, impaired judgement	Anxiety, dysphoria, irritability, autonomic hyperactivity, tremor, insomnia, nausea/vomiting, transient visual/tactile/auditory hallucinations, psychomotor agitation, grand-mal seizures; severe = DT-like delirium (can be FATAL)

Substance	Intoxication	Withdrawal
Hallucinogens (LSD)	Anxiety/depression, ideas of reference, fear of losing one's mind, paranoia, perceptual intensification, depersonalization/derealization, illusions, hallucinations, synaesthesia (full alertness), mydriasis, tachycardia, sweating, tremor; somatic -> mood/perceptual -> psychological sequence	No recognised physiological withdrawal; death may occur acting on false perceptions; possible flashbacks (HPPD)
Phencyclidine (PCP)	Agitation, rage, aggression, fear; vertical OR horizontal nystagmus, neuronal hyperexcitability (hyperreflexia to status epilepticus), hypertension, numbness/analgesia, ataxia, dysarthria, muscle rigidity; VARIABLE pupils	No clearly defined withdrawal syndrome in humans
MDMA (Ecstasy)	Initial disorientation then 'rush' (raised BP/pulse, sweating), euphoria, increased self-confidence, empathy/closeness, bruxism, decreased appetite (4-6 h); arrhythmia, dyspnoea, death	'Mini-crash' (same day or +2 days): fatigue, loss of appetite, depression, anxiety, poor concentration (resembles stimulant withdrawal)
Caffeine	> 250 mg: restlessness, nervousness, excitement, insomnia, flushed face, diuresis, GI disturbance, muscle twitching, rambling thought/speech, tachycardia/arrhythmia, inexhaustibility, agitation	NOT in DSM (research criteria): headache, marked fatigue/drowsiness, anxiety/depression, nausea/vomiting from ~100 mg/day; begins ~12 h, peaks 24-48 h, lasts up to 1 week
Nicotine	Not coded separately; main concern is cardiovascular & respiratory ill-health	Dysphoria/depressed mood, insomnia, irritability/anger, anxiety, poor concentration, restlessness, decreased heart rate, increased appetite/weight; begins hours after last cigarette, peaks 2-3 days, eases over 1-3 weeks; ~10 lb weight gain

Substance	Intoxication	Withdrawal
Inhalants	Dizziness, nystagmus, incoordination, slurred speech, unsteady gait, lethargy, depressed reflexes, psychomotor retardation, tremor, muscle weakness, blurred vision/diplopia, stupor/coma, euphoria; perioral rash, unusual breath odour	No dependence syndrome; no reliable withdrawal syndrome recorded (per DSM)
GHB	Euphoria, disinhibition, drowsiness; high dose: respiratory depression, coma	Similar to alcohol/BZD withdrawal: mild = insomnia, tremor, anxiety; severe = paranoia, hallucinations, psychotic behaviour, extreme agitation; starts 12 h, lasts up to 12 days
Steroids (anabolic)	Euphoria, hyperactivity, irritability, increased anger/hostility, anxiety, depression; correlation with violence	Depression, anxiety, body-image preoccupation on stopping

NOTE Pupil direction is the fastest discriminator: opioid intoxication causes **CONSTRICTION** (dilation signals severe overdose/anoxia) while withdrawal causes **DILATION**; stimulant intoxication dilates pupils while the withdrawal 'crash' brings **SMALL** pupils.

NOTE Two withdrawals can **KILL**: alcohol (delirium tremens, ~5%) and benzodiazepines (DT-like delirium, seizures). Opioid withdrawal ('cold turkey'), though intensely unpleasant, is rarely fatal in a healthy adult.

NOTE Stimulant (cocaine/amphetamine) withdrawal is dominated by a psychological 'crash' - dysphoria, hypersomnia, increased appetite, vivid unpleasant dreams - with strikingly **FEW** physical signs.

NOTE Vertical OR horizontal nystagmus with analgesia and muscle rigidity is the **PCP** signature; **LSD** instead produces vivid perceptual changes and synaesthesia with full alertness, following a somatic -> mood -> perceptual -> psychological sequence, and has no true withdrawal state.

KEY STATISTICS & PROPORTIONS

A comprehensive collection of frequently examined psychiatric statistics, percentages, and proportions — verified and corrected against standard texts. Figures are approximate and vary by study and population.

Mood & Psychosis

Statistic	Figure
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Statistic	Figure
Schizophrenia – risk if one parent affected	~9–14%; ~20% are treatment-resistant
Major depression – cortisol elevation	~50% (40% outpatients, 60% inpatients) show non-suppression
Depression – antidepressant non-response	~30–45% show no response
Depression – recurrence	~50% after 1st episode; ~80% after 2 episodes
Bipolar – completed suicide	~15% (15× general population)
Late-onset schizophrenia – female proportion	~60–69%
Post-stroke depression	~33–35% (anxiety ~25%, catastrophic reaction ~20%; mania/psychosis rare)
Mixed anxiety & depression (UK)	~9% meet criteria — one of the commonest disorders in Britain
SSRI – sexual side effects	~60%

NOTE Depression recurrence climbs with each episode: ~50% relapse after one episode and ~80% after two — the rationale for longer maintenance treatment in recurrent depression.

Neurocognitive

Statistic	Figure
Dementia – prevalence over 65	~8%; vascular ~15–20% of all dementias (2nd commonest)
Vascular dementia – depression	~40–50%
MCI → Alzheimer's conversion	~10–15%/year; only ~40% progress even after 10 years
Down syndrome – Alzheimer's by 65	~75% develop dementia; plaques/tangles in most by 40
Wernicke's → Korsakoff's	~80% of alcoholics recovering from Wernicke's develop Korsakoff's

Statistic	Figure
Wernicke's – classic triad present	Only ~10%; ~80% undiagnosed before post-mortem
Lewy body dementia – life expectancy	~6 years after diagnosis
Delirium – prevalence	Community ~1–2%; general hospital ~14–24%; post-op (>65) ~15–53%; ICU ~70–87%
Delirium – preventable proportion	~30–40% of cases
vCJD – psychiatric onset	Neurological symptoms precede psychiatric in only ~15%; ataxic onset ~10%

NOTE Wernicke's encephalopathy is dangerously under-recognised: the classic triad appears in only ~10% of cases and ~80% are diagnosed only at post-mortem — so treat on suspicion, never wait for the triad.

Child & Developmental

Statistic	Figure
Down syndrome risk – maternal age	~1/1200 at 25, ~1/900 at 30, ~1/350 at 35, ~1/100 at 40, ~1/10 at 49
Autism – epilepsy by 21	~22%; intellectual impairment ~40–70%; any anxiety disorder ~84%; ~⅓ remain dependent as adults
DiGeorge (22q11) – psychosis	Up to ~30% develop a psychotic illness
Fragile X – social anxiety	Up to ~75% excessive shyness; ~50% panic attacks
Enuresis	~50% more common in boys
Anorexia – sex ratio	~10× more common in females

NOTE Down syndrome risk by maternal age is a classic recall set: ~1/1200 at 25 rising to ~1/100 at 40 and ~1/10 at 49; ~75% develop Alzheimer's dementia by age 65.

Forensic

Statistic	Figure
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Statistic	Figure
Homicide – mental illness	~10% of offenders have active symptoms at offence; ~5% have schizophrenia; ~9% of homicides involve recent MH contact
Personality disorder in homicide	~9% of those convicted; schizophrenia 5%, affective 7%, alcohol 7%, drug 6%
Female-perpetrated homicide	~10–12% of homicides; male:female ratio ~8:1; victims usually partners (32%) or children (30%)
Paedophilia – offender relationship	~80% of offenders against children are relatives (13%) or known (68%); ~90% male; girls 2× likely victims
Indecent exposure – recidivism	~20% have no prior record; ~60% have prior sexual offences; ~20–30% reoffend
Antisocial PD in prisoners	Male remand ~63%, sentenced ~49%, female ~31%; general population ~0.6% (men 1%, women 0.2%)
Learning disability in prisons	~40% (broad screening estimates)
Being stalked (clinician)	~5–10%/year; ~20% over a career

NOTE In child sexual abuse, about 80% of offenders are relatives (~13%) or otherwise known to the child (~68%), ~90% are male, and girls are roughly twice as likely to be victims.

Substance & Other

Statistic	Figure
Clozapine – neutropenia & agranulocytosis	Neutropenia ~2.7% (some cite 1–2%); agranulocytosis ~0.8% (↓0.07% after year 1); sialorrhoea ~30% (10–80%)
Cocaine users – psychiatric comorbidity	~50–80% lifetime; ~60% report MH problems
Cannabis use disorder – comorbidity	Anxiety ~24%, bipolar I ~13%, major depression ~11%
Schizophrenia – substance misuse	~3× alcohol, ~6× drug abuse vs general population

Statistic	Figure
Benzodiazepine dependence	~15% if used 1–5 months; ~40% if used ~1 year
Hypochondriasis – comorbidity	~88% have another disorder (GAD 71%, dysthymia 45%, depression 43%); 3× more likely to have a PD
Postpartum psychosis	~0.1–0.25% general; ~50% in bipolar; 50–90% if prior PP psychosis; ~80% affective; infanticide ~4%
Antipsychotic – atrial fibrillation	~17% increased risk
Deliberate self-harm – outcome	~20% repeat & ~1% die within 1 year; ~10% eventually complete; > 90% have a mental disorder

NOTE Benzodiazepine dependence is strongly duration-dependent: ~15% after 1–5 months of use rises to ~40% after about a year — a key prescribing-safety figure.

OLD & HISTORICAL NAMES (COMPREHENSIVE)

Historical, obsolete, and alternative names for psychiatric disorders mapped to their modern terms - capturing the full source set with additions. A key history-of-psychiatry topic.

Old Name -> Modern Diagnosis

Modern Diagnosis	Old / Historical Name(s)
Delusional disorder	Monomania; paranoid disorder
Panic disorder	Soldier's heart, neurocirculatory asthenia, irritable heart
PTSD	War neurosis, soldier's heart (US Civil War), shell shock (WWI), battle fatigue, combat neurosis, post-Vietnam syndrome, post-rape/rape-trauma syndrome, delayed stress response, abused-child syndrome, battered-wife syndrome, accident syndrome
Schizophrenia	Dementia praecox

Modern Diagnosis	Old / Historical Name(s)
Learning disability	'Mental deficiency', 'feeble-minded', 'idiots', mental retardation
Bipolar disorder	Circular insanity (folie circulaire)
Functional neurological disorder	Conversion (hysteria)
GAD	Overanxious disorder of childhood
Asperger's	Autistic psychopathy
Somatization disorder	Briquet's syndrome; 'St. Louis hysteria'
Atypical depression	Hysteroid dysphoria
Seasonal depression	Winter depression, holiday blues, arctic blues
Dysthymia	Neurotic depression, 'chronic low-grade depression', 'pervasive lingering depressive disorder'
Bipolar depression	'Rock bottom depression' (greater severity vs unipolar)
Rapid cycling	'Cycle acceleration'
Social anxiety disorder	'Bashful bladder'; paruresis (fear of using public restroom)
Night terrors	Pavor nocturnus, sleep terrors
Kleine-Levin syndrome	'Sleeping Beauty' syndrome
Delirium	Organic brain syndrome, ICU psychosis, acute confusional state, acute brain failure, toxic-metabolic state, CNS toxicity, sundowning, cerebral insufficiency
22q11.2 deletion syndrome	Velocardiofacial, DiGeorge, or Shprintzen syndrome
Munchausen's by proxy	Fabricated or induced illness (FII)
REM sleep behaviour disorder	'Dream-enacting behaviours'
Lesch-Nyhan syndrome	Juvenile gout
GHB	'Georgia Home Boy', 'liquid ecstasy'

Modern Diagnosis	Old / Historical Name(s)
Pathological laughing & crying	Emotional incontinence/emotionalism, pseudobulbar affect
Infantile spasms	'Salaam attacks'
Periodic limb movement disorder	Nocturnal myoclonus
Delirium superimposed on dementia	Beclouded dementia
Delirium (post-cataract, eye patches)	Black-patch delirium
Depression with cognitive impairment	Pseudodementia; depression-related cognitive dysfunction
Mild neurocognitive disorder	Mild cognitive impairment (MCI)
Major neurocognitive disorder	Dementia
Childhood disintegrative disorder	Heller's syndrome, disintegrative psychosis
Autistic disorder	Early infantile autism, childhood autism, Kanner's autism

NOTE PTSD has accumulated more historical names than any other diagnosis - soldier's heart, shell shock, battle fatigue, combat neurosis - each tied to a war, reflecting how the concept evolved through military psychiatry.

NOTE Two neat eponym-to-modern mappings: Heller's syndrome = childhood disintegrative disorder, and Kanner's autism = autistic disorder (early infantile autism).

SEX DIFFERENCES (COMPREHENSIVE)

Differences between males and females across psychiatric disorders - onset, presentation, course, and treatment - capturing the full source set with additions.

Sex Differences by Disorder

Disorder	Sex Difference
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Disorder	Sex Difference
Anorexia nervosa	Incidence 10x higher in females
Bipolar disorder	Onset ~5 years EARLIER in males
Enuresis	~50% more common in boys than girls
Depression in old age	Female first-admissions peak at age 80 then fall; male admissions climb to end of life, OVERTAKING women at age 85
Suicide method (UK)	Men: hanging/strangulation/suffocation, then poisoning. Women: REVERSE - poisoning first, then hanging
Schizophrenia - males	Earlier onset, poorer premorbid function, more negative symptoms & cognitive deficits, greater structural/neurophysiological abnormality; families more critical (expressed emotion hits males harder)
Schizophrenia - females	Later onset, better treatment response, lower antipsychotic doses; more affective symptoms, auditory hallucinations, persecutory delusions; better short/mid-term course; more side effects
Schizophrenia - no sex difference	Family history, obstetric complications, minor physical anomalies, neurological soft signs
Alcohol use disorder	Commoner in men; women more sensitive (less gastric alcohol dehydrogenase, lower body water); TELESCOPING - faster progression to dependence in women, who seek treatment sooner
Depression - treatment seeking	Women treated more often & earlier; 50.5% of men receive no treatment at all
Schizoaffective disorder	Higher in women (mainly the depressive type)
Forensic (women)	Index offence more often 'romantic'/domestic; 68% imprisoned for non-violent offences (vs 47% men); victims more often family members
Epworth Sleepiness Scale	Cut-off >11 for men, >9 for women

NOTE Schizophrenia is strongly sex-dimorphic: males have earlier onset, poorer premorbid function, and more negative/cognitive symptoms, while females have later onset, better treatment response, and more affective symptoms.

NOTE 'Telescoping' describes the faster progression from use to dependence in women with alcohol use disorder - they become dependent sooner and seek treatment earlier, despite lower overall prevalence.

AGE-SEX PROFILES (COMPREHENSIVE)

The classic age and sex profile ('who gets it') for psychiatric syndromes, drug reactions, and forensic situations - capturing the full source set with additions. A key single-best-answer pattern.

Age-Sex Profile by Condition

Condition	Typical Profile
Serotonin syndrome	Older female
Agranulocytosis (clozapine)	Older female
Post-stroke depression	Younger female (<60)
Neuroleptic malignant syndrome	Younger male
Completed suicide (general)	Older male
Suicide in schizophrenia	Younger male
Suicide in multiple sclerosis	Younger male
Suicide in epilepsy	Younger male
Suicide in alcohol dependence	Male, older than 50
Dystonia	Younger male
Tardive dyskinesia	Older female
Lithium-induced hypothyroidism	Younger female
QTc prolongation	Older female
Ekbom syndrome (delusional parasitosis)	Older female
Restless legs (Ekbom)	Older female

Condition	Typical Profile
Antidepressant-induced hyponatraemia / SIADH	Older female
Psychotic depression	Older female
Anti-NMDA receptor encephalitis	Younger female
Drug-induced hepatotoxicity	Older female
Rapid cycling	Younger female
Pseudo-parkinsonism	Older female
Cotard's syndrome	Older female
Meige's syndrome	Middle-aged woman
Depression in Parkinson's disease	Younger female
Treatment-seeking failure/delay	Older men
Unipolar-to-bipolar switch	Younger male
Non-organic (psychogenic) visual loss	Younger female
Violence in mental illness	Younger male
Violence in learning disability	Younger male
Stranger homicide	Younger male
SSRI discontinuation syndrome	Younger male

NOTE Two drug-reaction profiles recur: tardive dyskinesia and QTc prolongation in OLDER FEMALES, versus acute dystonia and neuroleptic malignant syndrome in YOUNGER MALES.

NOTE Suicide profiles split by context: completed suicide in general and in alcohol dependence favours OLDER males, while suicide in schizophrenia, epilepsy, and MS favours YOUNGER males.

EPIDEMIOLOGY - ADDITIONAL STATISTICS (COMPREHENSIVE)

Additional epidemiological statistics and prevalence figures across psychiatry - capturing the full source set with additions. Figures are approximate.

Additional Statistics

Topic	Statistic
Psychosis in Alzheimer's (major NCD)	Median ~41% (range 12.2-74.1%)
Cannabis use disorder comorbidity	Anxiety 24%, bipolar I 13%, MDD 11%
Schizophrenia & substance	3x more likely to abuse alcohol, 6x more likely to abuse drugs
Clozapine haematological	Neutropenia ~2.7%, agranulocytosis ~0.8%
Depression in IHD/CHD	Major depression ~20%; minor ~27%
Depression in pregnancy	~10% symptomatic; 5.1% probable MDD; 4.8% milder
Postpartum blues	Resolves by week 2 in 80%; evolves to PPD in 20%
Postpartum psychosis recurrence	1/3 relapse in a subsequent pregnancy; risk 50% in bipolar, 50-90% with prior PP psychosis
Puerperal psychoses	80% are affective; follow 20-30% of births in pre-existing bipolar
Learning disability & schizophrenia	Prevalence ~3%
GAD course	Chronic; nearly half who recover later relapse
DSH & suicide	40-60% of suicides have prior DSH; 1-yr suicide risk after DSH 0.7% (66x); 15-yr: 4.8% males, 1.8% females
Sexually inappropriate behaviour (dementia)	7-25% (newer figures 10-19%)
Homicide & mental illness (Shaw 2006)	11-17% had symptoms; 5% linked to schizophrenia; 10% active symptoms at offence
Learning disability in prisons	~40%

NOTE People with schizophrenia are 3x more likely to abuse alcohol and 6x more likely to abuse drugs than the general population - a key dual-diagnosis statistic.

NOTE After deliberate self-harm, the 1-year suicide risk is ~0.7% (66x the general population) - higher in absolute terms in males but a greater relative excess in females.

MEDICINAL & PSYCHOACTIVE PLANTS (COMPREHENSIVE)

Plants and herbal remedies of psychiatric relevance - their active compounds, uses, and cautions - capturing the full source set with additions.

Plants & Herbal Remedies

Plant / Remedy	Note
Cocaine	Alkaloid from <i>Erythroxylon coca</i> (coca shrub, South America)
St John's Wort (<i>Hypericum perforatum</i>)	Only herbal with robust evidence in mild-moderate depression & dysthymia; CYP3A4 INDUCER (reduces ciclosporin, OCP, etc.); + SSRI = serotonin syndrome risk
Kava (<i>Piper methysticum</i>)	Only demonstrably effective herbal anxiolytic (kavapyrones - Na-channel block, GABA-A up, NA-reuptake block, glutamate suppression); reduces HAM-A within 1 week; WITHDRAWN - fatal hepatotoxicity; interacts with levodopa/alprazolam
Ginkgo biloba	Memory enhancement, dementia, tardive dyskinesia; ginkgolide B inhibits platelet-activating factor -> antiplatelet -> warfarin interaction & fatal cerebral bleeds
Khat (<i>Catha edulis</i>)	Stimulant from fresh leaves (East Africa, Yemen); active cathinone (more active than cathine) breaks down to cathine & norephedrine
Rauwolfia serpentina	Used in India >2000 yr for insanity; reserpine isolated 1953, introduced as antipsychotic 1954 - revealed roles of DA/NA/5-HT
Huperzine A (<i>Huperzia serrata</i>)	Reversible AChE inhibitor from Chinese herb; meta-analysis suggests cognitive benefit but poor trial quality
Cannabis (<i>Cannabis sativa</i>)	Hash & weed; >400 compounds; delta-9-THC responsible for potency/high
DMT (dimethyltryptamine)	Tryptophan derivative; from South American ayahuasca brew

Plant / Remedy	Note
LSD	Derived from seeds of morning glory (and ergot fungus)
Peony-Glycyrrhiza decoction	Herbal remedy shown to improve antipsychotic-induced hyperprolactinaemia symptoms
Not effective for anxiety	Ginkgo, valerian, passiflora (no efficacy vs diazepam); lavender, saffron, chamomile, lemon balm 'promising'

NOTE Two herbals with real evidence carry real risks: St John's Wort (effective in mild-moderate depression but a CYP3A4 inducer causing serotonin syndrome and drug interactions) and kava (effective anxiolytic but withdrawn for fatal hepatotoxicity).

NOTE Ginkgo biloba's ginkgolide B inhibits platelet-activating factor, creating a dangerous interaction with warfarin and reports of fatal cerebral bleeds - a frequently tested herb-drug interaction.

DRUG STREET NAMES (COMPREHENSIVE)

Street/slang names for drugs of misuse mapped to their pharmacological identity - capturing the full source set with additions.

Street Name -> Drug

Drug	Street Name(s)
Amphetamine	'Speed'
Methamphetamine	'Ice'
MDMA	'Ecstasy', 'love drug', 'Adam', 'E'
MDA	'Eve'
Psilocybin	'Mushrooms', 'magic mushrooms', 'shrooms'
Dimethyltryptamine	'DMT'
Mescaline	From peyote cactus
LSD	'Acid'
Phencyclidine	'Angel dust', PCP
Cannabis	Blow, dope, grass, hash, marijuana, weed, 'skunk' (potent form)

Drug	Street Name(s)
Cocaine	C, Charlie, coke, snow; 'crack' (freebase)
Mephedrone	'Meow-meow'
GHB	'Georgia Home Boy', 'liquid ecstasy'

NOTE Distinguish the MDMA family: MDMA = 'ecstasy'/'Adam'/'E', while MDA = 'Eve' - a small but examinable distinction.

NOTE 'Skunk' is a high-potency (high-THC) form of cannabis, and 'crack' is freebase cocaine - potency-related street terms worth knowing.

RISK IN RELATIVES (COMPREHENSIVE)

Recurrence risks and relative risks in first-degree relatives across psychiatric disorders - capturing the full source set with additions.

Risk in Relatives

Disorder	Risk in Relatives
Autism (1 affected child)	Sibling recurrence 2-8% (~50x; range 30-120x)
Autism (2 affected children)	Sibling risk 25-30% (~300x)
Somnambulism (sleepwalking)	Familial in up to 20%; if BOTH parents affected, risk ~60%
Night terrors	10-fold increase in first-degree relatives
Delayed sleep phase type	40% have a family history
Narcolepsy	5-15% of first-degree relatives develop it
OCD (adult-onset proband)	~2x in first-degree relatives
OCD (childhood/adolescent-onset)	~10-fold in first-degree relatives
Anorexia/bulimia (relatives)	Higher OCD, GAD, panic, substance misuse, mood disorders; morbid risk of affective disorder similar to bipolar probands (supports link to mood disorder)
Schizophrenia (one parent)	9-14% risk in children

Disorder	Risk in Relatives
Schizophrenia (treatment-resistant)	~20% of patients

NOTE Autism sibling risk escalates sharply: 2-8% (~50x) after one affected child, rising to 25-30% (~300x) after two - and OCD shows a similar pattern (childhood-onset confers ~10x relative risk vs ~2x for adult-onset).

NOTE If BOTH parents have somnambulism, the child's risk reaches ~60% - one of the highest single familial risk figures in the sleep disorders.

THINGS TO AVOID (COMPREHENSIVE)

Interventions and approaches to AVOID in specific conditions - the 'do nots' of psychiatric management. Capturing the full source set with additions.

Things to Avoid by Condition

Condition	Avoid
PTSD	Do NOT offer single-session debriefing / psychological ventilation (may worsen outcome)
Conversion disorder	Avoid confrontation (challenging the patient that symptoms are 'not real')
Somatization disorder	Do NOT encourage repeated medical visits/investigations (reinforces illness behaviour)
Injecting opioid use	Do NOT use lemon juice to reconstitute (acidifier) - associated with Candida endophthalmitis
Borderline PD (psychotherapy)	Therapist should NOT be a passive listener (active, structured stance needed)
Lewy body dementia	Avoid (typical) antipsychotics - severe neuroleptic sensitivity can be fatal
Parkinson's disease	Avoid dopamine-blocking antipsychotics (worsen motor symptoms)
MAOI	Avoid tyramine-rich foods & sympathomimetics (hypertensive crisis)

Condition	Avoid
Bipolar depression	Avoid antidepressant monotherapy (switch/cycle-acceleration risk)

NOTE Two classic 'do not's': avoid single-session debriefing after trauma (it can worsen PTSD), and avoid confronting the patient with conversion disorder about the reality of their symptoms.

NOTE Never use typical antipsychotics in Lewy body dementia - the severe neuroleptic sensitivity reaction can be fatal.

ETHNICITY & PSYCHIATRY (COMPREHENSIVE)

Associations between ethnicity and psychiatric risk, pharmacogenomics, and drug reactions - capturing the source with additions. Apply cautiously and individually.

Ethnicity-Related Associations

Topic	Association
Metabolic syndrome	More common in Asian and Afro-Caribbean people
Clozapine agranulocytosis	Risk increased with Asian race (and increasing age)
Benign ethnic neutropenia	Common in people of African/Afro-Caribbean & Middle Eastern descent (lower baseline neutrophils - affects clozapine monitoring)
Schizophrenia (AESOP)	~9x in African-Caribbean, ~6x in Black African vs White British (UK)
Carbamazepine SJS/TEN	HLA-B*1502 (Han Chinese, SE Asian) - screen before prescribing
Carbamazepine hypersensitivity	HLA-A*3101 (European, Japanese)
CYP2D6 poor metabolisers	More common in Caucasians (~7-10%); ultra-rapid metabolisers commoner in East African/Middle Eastern
Lithium response	Some evidence of variation; renal clearance differences across populations

NOTE Benign ethnic neutropenia (common in people of African and Middle Eastern descent) lowers baseline neutrophil counts and must be accounted for in clozapine monitoring to avoid unnecessary discontinuation.

NOTE HLA-B*1502 (Han Chinese, SE Asian) predicts carbamazepine-induced Stevens-Johnson syndrome/TEN - screening is recommended before prescribing in these populations.

RISK MULTIPLIERS (COMPREHENSIVE)

'How many times' relative-risk multipliers - capturing the full source set with additions. Complements the Increased Risk compilation.

Risk Multipliers

Factor	Multiplier
Alcohol disorder (17-yr-old male, father chronic alcoholic)	4x
Suicide in paranoid vs non-paranoid patients	3x
Postpartum psychosis recurrence (after one episode)	1 in 3
Cannabis & schizophrenia	2x (and ~4x for psychosis)
ADHD in sibling	5x
Autism in sibling	3x (per this source; other estimates higher)
Mental disorder in children of lone parents	2x (vs married-couple households)
Psychotic disorders in prison vs general population	10x
Violent victimisation in mental illness	5x

NOTE Quick multipliers to memorise: psychotic disorders in prison ~10x, violent victimisation in mental illness ~5x, ADHD in a sibling ~5x, and alcohol disorder ~4x with a chronically alcoholic father.

NOTE Cannabis roughly doubles schizophrenia risk (and quadruples psychosis risk) - the headline substance-use multiplier in psychiatry.

SEASONALITY (COMPREHENSIVE)

Seasonal patterns in psychiatric disorders - by birth month and by episode timing - capturing the full source set with additions.

Seasonal Patterns

Disorder	Seasonal Pattern
Mania	Increased in SUMMER months (rarely a seasonal pattern within an individual)
Schizophrenia (birth)	Increased rates in those born January-March (late winter/early spring)
ADHD (birth)	September is the peak birth month
Reading disorder (birth)	Most frequent in children born May-July
Suicide	Peak in MAY, with a second peak in October
Bipolar depression	Depressive episodes commoner in spring & autumn; manic episodes in summer
Deficit syndrome schizophrenia	Associated with summer birth
Seasonal affective disorder	Winter depression (low light); responds to bright-light therapy

NOTE Birth-month seasonality recurs in neurodevelopmental conditions: schizophrenia (Jan-Mar births), ADHD (September peak), and reading disorder (May-July births).

NOTE Mania peaks in summer and suicide in May (with a smaller October peak) - episode-timing patterns distinct from the birth-month effects.

APHORISMS & CLINICAL SAYINGS (COMPREHENSIVE)

Memorable clinical aphorisms and sayings in psychiatry - capturing the full source set with additions.

Aphorisms

Topic	Aphorism
Maintenance dosing	'The dose that gets you well keeps you well'

Topic	Aphorism
The four 'rights'	Expect a positive response with the RIGHT drug, RIGHT dose, RIGHT duration, RIGHT diagnosis
Social anxiety disorder	'A stare is a threat'
Self-harm in over-65s	'All acts of self-harm in people over 65 should be regarded as evidence of suicidal intent until proven otherwise'

NOTE 'The dose that gets you well keeps you well' encapsulates the principle that the acute treatment dose is generally the maintenance dose - avoid reflexive dose reduction after recovery.

NOTE 'All self-harm in over-65s is suicidal intent until proven otherwise' reflects the high lethality and intent behind late-life self-harm.

SMALL TERMS & SIGNS (COMPREHENSIVE)

Easily-confused small terms and clinical signs - capturing the full source set with additions.

Terms & Signs

Term / Sign	Meaning
Mirror gazing	Hebephrenic schizophrenia (spending long periods before a mirror)
Mirror sign	Alzheimer's disease (failure to recognise one's own reflection)
Negative autoscopy / mirror test	Failure to see one's own reflection ('mirroring')

NOTE Don't confuse the 'mirror' signs: mirror **GAZING** (prolonged self-viewing) suggests hebephrenic schizophrenia, whereas the mirror **SIGN** (failure to recognise one's reflection) suggests Alzheimer's disease.

KEY STATISTICS & PROPORTIONS (COMPREHENSIVE)

A comprehensive collection of key psychiatric statistics, prevalences, and proportions - capturing the full (very rich) source set with additions. Figures are approximate and study-dependent.

Disorders & Genetic Syndromes

Topic	Statistic
Lithium hypothyroidism	5-10% (women 14% vs men 4.5%); highest in first 2 yr & women starting at 40-59; 1 in 10 malformation if continued through 1st trimester
Korsakoff's	~80% recovering from Wernicke's develop Korsakoff's amnesia
Fragile X	Up to 75% of males excessively shy; 50% have panic attacks
Ketamine	Up to 30% of chronic users have urinary symptoms
Schizophrenia	9-14% risk in child if one parent affected; ~20% treatment-resistant
Bipolar	~15% complete suicide
Autism	22% develop epilepsy by 21; social phobia 17-30%; any anxiety ~84%; intellectual impairment 40-75%; ~2/3 of adults remain severely handicapped
Antisocial PD (in a forensic group)	Prevalence 47%; alcohol misuse/dependence 18-30%; PTSD ~21%; depression 10%; psychosis 4%
DiGeorge syndrome	Up to 30% develop a psychotic illness

NOTE Autism carries a heavy comorbidity load: ~22% develop epilepsy by 21, ~84% have some anxiety disorder, 40-75% have intellectual impairment, and about two-thirds of adults remain severely dependent.

Dementia, Delirium & Perinatal

Topic	Statistic
Down syndrome (maternal age)	25 yr ~1/1200; 30 yr ~1/900; 35 yr ~1/350; 40 yr ~1/100; 49 yr ~1/10
Down syndrome (dementia)	~25% cognitive impairment by 35; ~75% Alzheimer's by 65; plaques & tangles by 40 in most
Vascular dementia	Depression in 40-50%; dementia prevalence ~8% over 65 (10-40% vascular)

Topic	Statistic
MCI -> Alzheimer's	~10-15%/yr; conversion 5-10%/yr; only ~40% progress even after 10 yr
Lewy body dementia	Average life expectancy ~6 yr after diagnosis
Delirium	30-40% preventable; community 1-2%; hospital 14-24%; post-op (>65) 15-53%; ICU 70-87%
Depression & somatoform	~50% of depression/anxiety patients have significant somatoform symptoms
Hypochondriasis	88% have another disorder: GAD 71%, dysthymia 45%, depression 43%, somatization 21%, panic 17%; 3x more likely to have a PD
Postpartum psychosis	Suicide ~2/1000 (leading cause of maternal death, violent means); infanticide ~4%

NOTE Down syndrome risk by maternal age is a classic exam figure: ~1/1200 at 25, ~1/350 at 35, ~1/100 at 40, and ~1/10 at 49.

Forensic, Substance & Suicide

Topic	Statistic
Female-perpetrated homicide	10-12% (England & Wales); M:F ratio 8:1; victim median age 40, usually partner/child & male
Cocaine users	60% admit mental health problems; lifetime psychiatric disorder 50-80% in long-term users
Wernicke's encephalopathy	Classic triad present in only 10%; 80% undiagnosed before post-mortem
Antidepressant response	30-45% show no response
Major depression (cortisol)	~50% show cortisol elevation (40% outpatients, 60% inpatients)
Suicide (children/adolescents)	10-14 yr: 1-2/100,000; 15-19 yr: 4-8/100,000; 1% of school children recent attempt, 2% threats

Topic	Statistic
Suicide & primary care	20% saw GP same day, 40-50% within a week, 70% within a month
Homicide & mental illness	~50/yr by those in recent contact with services (9% of all); 5% schizophrenia; 34% related to mental disorder (Shaw 2006)
Paedophilia	80% of offenders are relatives (13%) or known (68%); 90% male; 1/3 are adolescents; girls 2x more likely victims
Clozapine	Sialorrhoea ~30% (range 10-80%); agranulocytosis 0.7% (0.07% after first year); neutropenia 1-2%
Late-onset schizophrenia	60-69% female

NOTE Wernicke's encephalopathy is massively underdiagnosed: the classic triad (confusion, ataxia, nystagmus) appears in only ~10%, and ~80% are diagnosed only at post-mortem.

OUTDATED & REVISED BELIEFS (COMPREHENSIVE)

Beliefs in psychiatry that have been revised or overturned by newer evidence - 'what used to be thought versus what we now think'. Capturing the full source set with additions.

Outdated vs Current View

Topic	Outdated Belief -> Current View
Tardive dyskinesia & female sex	Historically female gender was thought a risk factor; current evidence does NOT support sex as a risk factor
Conduct disorder -> antisocial PD	Traditionally ~40% persistence; NESARC data suggest this was an UNDERestimate - nearly 75% of adults with childhood conduct disorder meet ASPD criteria
Disulfiram mechanism	Earlier viewed as AVERSION therapy (conditioned response via disulfiram-ethanol reaction); now considered a DETERRENT, and the induced reaction is no longer routinely demonstrated

Topic	Outdated Belief -> Current View
Opiate dependence in pregnancy	Previously all patients withdrawn before delivery; now methadone MAINTENANCE preferred (abstinence rarely achievable); if withdrawing, do so in 2nd trimester, reducing methadone by 2-2.5 mg every 7-10 days
Hyperthyroidism & anxiety	Despite anxiety being cardinal, anxiety disorders occur in only ~15%; MAJOR DEPRESSION is the commonest psychiatric manifestation (~25%)
Interferon beta & depression (MS)	Initially linked to depression & suicide; more recent studies show the association is less robust (baseline/prior depression is the better predictor); BNF still cautions against use with severe depression/suicidal ideation

NOTE The conduct-disorder figure was revised UPWARD: long thought that ~40% progress to antisocial personality disorder, NESARC data suggest nearly 75% of adults with childhood conduct disorder meet ASPD criteria.

NOTE In hyperthyroidism, despite anxiety being the cardinal symptom, MAJOR DEPRESSION (~25%) is actually the commonest psychiatric manifestation - anxiety disorders appear in only ~15%.

CBT TECHNIQUES (COMPREHENSIVE)

A comprehensive reference to cognitive behavioural therapy techniques - cognitive and behavioural methods, the cognitive distortions they target, disorder-specific models, and third-wave developments. CBT is a structured, time-limited, collaborative, present-focused therapy based on the cognitive model that thoughts, feelings, and behaviours are interconnected. A key psychotherapy topic.

Cognitive Techniques

Technique	Description
Socratic questioning (guided discovery)	Using systematic questions to help the patient examine and re-evaluate their own beliefs, rather than the therapist directly challenging them
Thought records / diaries	Recording situation, automatic thought, emotion, and evidence for/against - the core CBT self-monitoring tool (e.g. 5-column dysfunctional thought record)

Technique	Description
Cognitive restructuring	Identifying, challenging, and modifying maladaptive automatic thoughts and core beliefs; replacing them with balanced alternatives
Examining the evidence	Listing objective evidence that supports and refutes a negative automatic thought to test its accuracy
Decatastrophizing ('what if')	Asking 'what is the worst that could happen, and could I cope?' to reduce catastrophic predictions
Cost-benefit (advantages/disadvantages) analysis	Weighing the pros and cons of holding a belief or continuing a behaviour
Pie chart / responsibility pie	Reattributing causality by allocating proportions of responsibility across multiple factors (used in guilt, OCD)
Downward arrow technique	Repeatedly asking 'if that were true, what would it mean?' to uncover underlying core beliefs/schemas
Identifying cognitive distortions	Labelling thinking errors (e.g. catastrophizing, all-or-nothing) to create distance from them
Continuum technique	Placing a belief on a scale/continuum to counter all-or-nothing thinking
Positive data log	Recording evidence consistent with a new, healthier belief to strengthen it
Reattribution	Generating alternative explanations for events rather than the default negative attribution

NOTE Socratic questioning (guided discovery) is the defining stance of CBT - the therapist helps patients re-evaluate their OWN beliefs through questioning rather than directly persuading them.

NOTE The downward arrow technique ('if that were true, what would it mean?') moves from surface automatic thoughts down to the underlying core beliefs and schemas that drive them.

Behavioural Techniques

Technique	Description
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Technique	Description
Behavioural activation	Scheduling and increasing rewarding/meaningful activities to break the inactivity-low mood cycle (core for depression; can be a standalone treatment)
Activity scheduling & monitoring	Planning activities and rating mastery and pleasure (M&P) for each
Graded exposure	Systematic, hierarchical confrontation of feared stimuli until anxiety habituates; in vivo, imaginal, or interoceptive
Exposure and response prevention (ERP)	Exposure to the trigger while preventing the compulsive/safety response - the gold-standard behavioural treatment for OCD
Systematic desensitization	Pairing graded exposure with relaxation (reciprocal inhibition; Wolpe) - used in specific phobias
Flooding / implosion	Prolonged exposure to the most feared stimulus without graduation until anxiety subsides
Fear hierarchy construction	Ranking feared situations by subjective units of distress (SUDs, 0-100) to guide exposure
Behavioural experiments	Designing real-world tests to gather evidence for/against a belief (e.g. dropping a safety behaviour to test a prediction)
Dropping safety behaviours	Eliminating subtle avoidance/checking that maintains anxiety and prevents disconfirmation of fears
Relaxation training	Progressive muscle relaxation, controlled (diaphragmatic) breathing - reduce physiological arousal
Applied relaxation (Ost)	Rapidly deployable relaxation skills applied at the first sign of anxiety (used in GAD, panic)
Applied tension (Ost)	Tensing large muscle groups to RAISE blood pressure - specific for blood-injection-injury phobia with vasovagal fainting
Stimulus control	Restructuring environmental cues (e.g. bed only for sleep) - core of CBT for insomnia (CBT-I)

Technique	Description
Response cost / contingency management	Operant techniques linking behaviour to consequences (rewards/penalties)
Worry postponement / stimulus control of worry	Confining worry to a set 'worry period' (used in GAD)
Problem-solving training	Structured steps: define problem, brainstorm, evaluate, implement, review
Grading of tasks	Breaking overwhelming tasks into achievable steps to build mastery

NOTE Two Ost techniques are opposites used for opposite problems: applied RELAXATION (lowering arousal in GAD/panic) versus applied TENSION (raising blood pressure to prevent fainting in blood-injection-injury phobia).

NOTE Exposure and response prevention (ERP) is the gold-standard behavioural treatment for OCD; graded exposure plus dropping safety behaviours underlies treatment of the phobias and panic.

Cognitive Distortions (Thinking Errors)

Distortion	Description
All-or-nothing (dichotomous) thinking	Seeing things in black-and-white, absolute categories ('If I'm not perfect, I'm a failure')
Overgeneralization	Drawing a sweeping conclusion from a single event ('I always fail')
Mental filter (selective abstraction)	Focusing exclusively on a single negative detail, ignoring the wider picture
Disqualifying the positive	Rejecting positive experiences as 'not counting'
Jumping to conclusions	Mind-reading (assuming others' negative thoughts) and fortune-telling (predicting bad outcomes)
Magnification / minimization	Exaggerating problems or shrinking positives ('catastrophizing' is the extreme of magnification)
Emotional reasoning	Treating feelings as facts ('I feel guilty, so I must be guilty')
Should statements	Rigid 'musts/oughts/shoulds' generating guilt and frustration (Ellis's 'musturbation')

Distortion	Description
Labelling / mislabelling	Attaching a global negative label to oneself or others ('I'm a loser')
Personalization	Attributing external events to oneself without basis (excessive self-blame)
Catastrophizing	Assuming the worst possible outcome will occur and be unbearable

NOTE Beck's cognitive distortions are the 'thinking errors' patients learn to identify and label; catastrophizing (an extreme of magnification) and all-or-nothing thinking are the most frequently targeted.

Disorder-Specific CBT Models

Disorder (Model)	Key Features
Depression (Beck)	Cognitive triad (negative view of self, world, future); behavioural activation + cognitive restructuring; schemas & negative automatic thoughts
Panic disorder (Clark)	Catastrophic misinterpretation of benign bodily sensations; interoceptive exposure + dropping safety behaviours
OCD (Salkovskis)	Inflated responsibility & thought-action fusion; ERP + responsibility/appraisal work
Social anxiety (Clark & Wells)	Self-focused attention, safety behaviours, negative self-image; video feedback, attention training, behavioural experiments
PTSD (Ehlers & Clark)	Trauma-focused CBT - reliving/imaginal exposure, cognitive restructuring of appraisals, reclaiming life; updating trauma memory
GAD (Borkovec / Dugas)	Worry as cognitive avoidance; intolerance of uncertainty; worry postponement, worry exposure
Health anxiety (Warwick & Salkovskis)	Misinterpretation of bodily signs; reduce checking/reassurance-seeking, behavioural experiments

Disorder (Model)	Key Features
Insomnia (CBT-I)	Stimulus control, sleep restriction, sleep hygiene, cognitive work - first-line for chronic insomnia
Bulimia/BED (Fairburn CBT-E)	Enhanced CBT - regular eating, addressing over-evaluation of shape/weight, dietary restraint
Psychosis (CBTp)	Normalising, examining evidence for delusions, coping strategy enhancement for hallucinations; NICE-recommended adjunct

NOTE Each anxiety disorder has a signature cognitive model: Clark's catastrophic misinterpretation (panic), Clark & Wells's self-focused attention and safety behaviours (social anxiety), and Salkovskis's inflated responsibility (OCD).

NOTE Beck's cognitive triad - negative views of the self, the world, and the future - is the foundational cognitive model of depression.

Third-Wave & Modern Developments

Therapy	Description
Mindfulness-Based Cognitive Therapy (MBCT)	Mindfulness + CBT; reduces RELAPSE in recurrent depression (≥ 3 episodes) - NICE-recommended
Dialectical Behaviour Therapy (DBT)	Linehan; mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness - evidence-based for borderline PD & self-harm
Acceptance and Commitment Therapy (ACT)	Psychological flexibility through acceptance, defusion, values, committed action (not symptom elimination)
Compassion-Focused Therapy (CFT)	Gilbert; develops self-compassion to counter shame and self-criticism
Schema Therapy (Young)	Integrates CBT with attachment/gestalt; targets early maladaptive schemas - used in personality disorders
Behavioural Activation (as standalone)	Evidence as an effective standalone treatment for depression (COBRA trial)
Metacognitive Therapy (Wells)	Targets metacognitive beliefs about worry/rumination (CAS - cognitive attentional syndrome)

Therapy	Description
MBSR (Kabat-Zinn)	Mindfulness-Based Stress Reduction - the precursor programme for stress and chronic conditions

NOTE MBCT is specifically evidence-based and NICE-recommended for PREVENTING RELAPSE in people with three or more previous episodes of depression, rather than for treating an acute episode.

NOTE DBT (Linehan) is the best-established psychotherapy for borderline personality disorder and recurrent self-harm, built on four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

DEFENCE MECHANISMS (COMPREHENSIVE)

Ego defence mechanisms organised by maturity level (after Vaillant and the psychodynamic tradition), with definitions and clinical examples. Defences are unconscious processes that protect the mind from anxiety and unacceptable impulses; their maturity correlates with psychological health and prognosis. A key psychotherapy and psychopathology topic.

Level 1: Psychotic / Pathological Defences

Defence	Definition & Example
Denial	Refusing to accept an external reality because it is too threatening; ignoring obvious facts (e.g. a patient with terminal illness behaving as if perfectly well). Psychotic denial involves gross impairment of reality testing
Distortion	Grossly reshaping external reality to suit inner needs - includes unrealistic grandiose beliefs, hallucinations, wish-fulfilling delusions, and sustained feelings of delusional superiority/entitlement
Delusional projection	Frank delusions about external reality, usually persecutory; attributing one's own unacceptable feelings to others to a delusional degree (e.g. paranoid delusions)
Splitting (psychotic)	Viewing self and others as all-good or all-bad, unable to integrate positive and negative qualities into a coherent whole

NOTE The psychotic defences (denial, distortion, delusional projection) share a GROSS impairment of reality testing - they are common in psychosis, dreams, and early childhood, and are 'rewritten' rather than relabelled by interpretation.

Level 2: Immature Defences

Defence	Definition & Example
Projection	Attributing one's own unacknowledged feelings/impulses to others (e.g. 'He hates me' when the patient hates him); basis of prejudice, suspiciousness, and pathological jealousy
Projective identification	Projecting unwanted feelings onto another AND subtly pressuring them to actually experience those feelings; the other person identifies with what is projected (key in borderline PD)
Acting out	Expressing an unconscious wish or impulse through action to avoid being conscious of the accompanying affect (e.g. tantrums, self-harm, deliberate provocations)
Passive aggression	Expressing aggression toward others indirectly through passivity, procrastination, inefficiency, masochism, or turning against the self
Regression	Returning to an earlier developmental stage to avoid the tension of the present (e.g. an ill adult becoming childlike and dependent; enuresis after birth of a sibling)
Somatization	Converting psychological distress into physical (bodily) symptoms and preoccupation with them
Schizoid fantasy	Retreating into one's own inner world of fantasy to avoid conflict and gratify needs (autistic withdrawal, daydreaming to resolve conflict)
Introjection	Internalising the qualities of an external object/person; can defuse aggression (identifying with a feared aggressor) or preserve a lost object
Idealization	Attributing exaggerated positive qualities to another (often paired with devaluation in splitting)
Devaluation	Attributing exaggerated negative qualities to self or others
Denial (neurotic)	Avoiding awareness of a painful aspect of reality (milder than psychotic denial; reality testing largely intact)

NOTE Immature defences (projection, acting out, passive aggression, regression, projective identification) dominate in personality disorders (especially borderline), adolescence, and substance misuse - and tend to provoke strong reactions in others.

NOTE Projective identification (immature) differs from simple projection: the person not only projects an unwanted feeling but unconsciously **PRESSURES** the recipient to actually feel and act on it - a hallmark of borderline personality dynamics.

Level 3: Neurotic Defences

Defence	Definition & Example
Repression	The cornerstone defence - unconsciously expelling unacceptable thoughts, feelings, or impulses from awareness (differs from suppression, which is conscious)
Displacement	Transferring feelings from one (threatening) object to another, safer one (e.g. anger at the boss taken out on the family; basis of phobias and transference)
Reaction formation	Transforming an unacceptable impulse into its opposite (e.g. excessive kindness masking hostility; over-solicitude; 'killing with kindness')
Isolation of affect	Separating an idea from the emotion attached to it - describing a traumatic event with no feeling; common in OCD
Intellectualization	Using excessive, abstract thinking and reasoning to avoid disturbing feelings (e.g. a patient discussing the statistics of their illness rather than their fear)
Rationalization	Offering plausible but false (self-justifying) reasons for behaviour driven by unacceptable motives ('sour grapes', 'sweet lemons')
Undoing	Performing an act (often ritualistic) to symbolically negate or atone for a previous unacceptable thought/act; magical reparation seen in OCD
Dissociation	Temporarily but drastically modifying one's sense of identity or consciousness to avoid emotional distress (e.g. fugue, derealization, 'la belle indifference')
Controlling	Excessively managing or regulating events/objects/people to minimise anxiety and resolve internal conflict

Defence	Definition & Example
Externalization	Perceiving one's own personality elements - drives, conflicts, moods - in the outside world and others (broader than projection)
Sexualization	Endowing an object or function with sexual significance it did not previously have, to ward off anxiety
Inhibition	Consciously or unconsciously limiting or renouncing some ego function to avoid anxiety arising from conflict

NOTE Repression (unconscious) is the cornerstone neurotic defence and must be distinguished from suppression (conscious, and MATURE) - a classic exam trap.

NOTE OCD is built on a recognisable triad of neurotic defences: isolation of affect, undoing (magical reparation), and reaction formation.

Level 4: Mature Defences

Defence	Definition & Example
Altruism	Vicarious but constructive and gratifying service to others (constructive reaction formation) - meeting one's own needs through helping others
Humour	Overt expression of feelings without personal discomfort and without unpleasant effect on others - permits one to bear, yet focus on, what is too terrible to be borne
Sublimation	Channelling unacceptable impulses into socially acceptable, even admirable, outlets (e.g. aggression into surgery or sport); impulse is acknowledged, modified, and directed
Suppression	The CONSCIOUS or semi-conscious decision to postpone attention to an impulse or conflict (differs from repression, which is unconscious)
Anticipation	Realistic planning for future inner discomfort - goal-directed, often slightly distressing, deliberate preparation for future difficulty

Defence	Definition & Example
Asceticism	Eliminating the pleasurable effects of experiences; moral element in assigning values to specific pleasures; gratification derived from renunciation

NOTE Vaillant's five mature defences - altruism, humour, sublimation, suppression, anticipation (plus asceticism) - are associated with successful adaptation, psychological health, and good long-term outcomes in the Harvard Grant Study.

NOTE Three pairs are easily confused: suppression (conscious, mature) vs repression (unconscious, neurotic); sublimation (impulse redirected usefully) vs reaction formation (impulse reversed); altruism (mature) vs projection (immature).

PSYCHOTHERAPY MODELS & FOUNDERS (COMPREHENSIVE)

The major schools of psychotherapy, their founders, and core concepts - capturing the full landscape from psychoanalysis to third-wave therapies. A key psychotherapy topic.

Schools of Psychotherapy

School / Therapy	Founder & Core Concepts
Psychoanalysis	Sigmund Freud - unconscious conflict, free association, transference, dream analysis; 3-5x/week on the couch
Analytical psychology	Carl Jung - collective unconscious, archetypes, individuation, introversion/extraversion
Individual psychology	Alfred Adler - inferiority complex, striving for superiority, birth order, social interest
Ego psychology	Anna Freud, Hartmann - defence mechanisms, adaptation, conflict-free ego sphere
Object relations	Klein, Fairbairn, Winnicott - internalised relationships; good/bad objects; 'good-enough mother', transitional object
Self psychology	Heinz Kohut - narcissism, selfobjects, empathic mirroring, fragmentation
Interpersonal psychoanalysis	Harry Stack Sullivan - the self as a product of relationships

School / Therapy	Founder & Core Concepts
Attachment-based	John Bowlby - attachment as a biological need; mentalization (Fonagy)
Behaviour therapy	Wolpe, Skinner, Pavlov - classical & operant conditioning, learning principles
Cognitive therapy	Aaron Beck - cognitive triad, schemas, automatic thoughts
Rational emotive behaviour therapy (REBT)	Albert Ellis - ABC model (Activating event, Belief, Consequence); irrational beliefs
Person-centred (client-centred)	Carl Rogers - unconditional positive regard, empathy, congruence; the actualizing tendency
Gestalt therapy	Fritz Perls - here-and-now awareness, 'empty chair', wholeness
Existential therapy	Yalom, Frankl (logotherapy), May - meaning, death, freedom, isolation
Logotherapy	Viktor Frankl - the search for meaning; paradoxical intention
Transactional analysis	Eric Berne - Parent-Adult-Child ego states; games; life scripts
Interpersonal therapy (IPT)	Klerman & Weissman - grief, role transition, role dispute, interpersonal deficits; for depression
Systemic / family therapy	Minuchin (structural), Bowen, Milan group - the family as a system; circular causality
Cognitive analytic therapy (CAT)	Anthony Ryle - integrates CBT + psychodynamic; reformulation letters, reciprocal roles
Dialectical behaviour therapy (DBT)	Marsha Linehan - for borderline PD; dialectics of acceptance & change
Motivational interviewing	Miller & Rollnick - resolving ambivalence; stages of change (Prochaska & DiClemente)

NOTE Match founder to school: Freud (psychoanalysis), Jung (analytical), Adler (individual), Rogers (person-centred), Perls (gestalt), Beck (cognitive), Ellis (REBT), Berne (transactional analysis), Linehan (DBT), Frankl (logotherapy).

NOTE Interpersonal therapy (IPT) targets four specific problem areas - grief, role transition, role dispute, and interpersonal deficits - and is evidence-based for depression.

TRANSFERENCE & COUNTERTRANSFERENCE (COMPREHENSIVE)

Transference, countertransference, and related psychodynamic process concepts - their types and clinical manifestations. A key psychodynamic topic.

Transference, Countertransference & Process

Concept	Definition
Transference (definition)	Unconscious redirection of feelings/attitudes from a significant past figure onto the therapist
Positive transference	Friendly, affectionate, trusting feelings toward the therapist (can aid the alliance)
Negative transference	Hostile, distrustful, angry feelings toward the therapist
Erotic / eroticized transference	Sexual/romantic feelings toward the therapist; eroticized form is intense, ego-dystonic, demanding
Transference neurosis	Re-creation of the patient's central conflicts within the therapeutic relationship
Countertransference (definition)	The therapist's emotional reaction to the patient (total response, or specifically the therapist's own unconscious transference)
Concordant countertransference	Therapist empathically identifies with the patient's own feelings (Racker)
Complementary countertransference	Therapist identifies with a significant figure from the patient's life (e.g. a critical parent)
Projective identification	Patient projects feelings onto therapist and pressures them to feel/act accordingly - a key source of countertransference
Acting out vs acting in	Enacting conflicts outside (acting out) vs within (acting in) the session

Concept	Definition
Therapeutic (working) alliance	The conscious, collaborative bond between patient and therapist - distinct from transference; the strongest predictor of outcome
Resistance	Conscious or unconscious opposition to the therapeutic process (e.g. lateness, silence, intellectualizing)

NOTE Racker's two countertransference types are commonly tested: **CONCORDANT** (therapist identifies with the patient's feelings) versus **COMPLEMENTARY** (therapist identifies with a figure from the patient's past, e.g. a critical parent).

NOTE The therapeutic (working) alliance is distinct from transference - it is the conscious collaborative bond, and is the single strongest predictor of psychotherapy outcome.

FREUD'S THEORIES (COMPREHENSIVE)

Freud's structural, topographic, psychosexual, and dream theories - the foundation of psychoanalytic thought. A key history and psychodynamic topic.

Structural Model

Structure	Features
Id	Unconscious; reservoir of instinctual drives; operates on the PLEASURE principle; primary-process thinking; present from birth
Ego	Conscious & unconscious; mediates between id, superego, and reality; REALITY principle; secondary-process thinking; defence mechanisms
Superego	Conscience and ego-ideal; internalised moral standards (from the resolution of the Oedipus complex); largely unconscious

NOTE The structural model maps onto principles: id = pleasure principle (primary process), ego = reality principle (secondary process), superego = morality - with the ego mediating among all three plus reality.

Topographic Model

Level	Description
Conscious	Thoughts currently in awareness

Level	Description
Preconscious	Accessible to awareness with effort (memory)
Unconscious	Repressed material not directly accessible; revealed via dreams, slips, free association

Psychosexual Stages

Stage	Features
Oral (0-1.5 yr)	Pleasure from the mouth; fixation -> dependency, smoking, sarcasm ('oral character')
Anal (1.5-3 yr)	Toilet training; fixation -> orderliness, parsimony, obstinacy (anal triad) or messiness
Phallic (3-6 yr)	Oedipus/Electra complex, castration anxiety/penis envy; superego forms
Latency (6-12 yr)	Sexual drives dormant; skill & peer development
Genital (12+ yr)	Mature sexuality directed toward others

NOTE The anal triad of fixation - orderliness, parsimony, and obstinacy - maps onto traits later described in obsessive-compulsive personality.

Dream Theory

Concept	Description
Manifest content	The dream as remembered/recounted
Latent content	The hidden unconscious meaning (wish)
Dream-work	The process transforming latent into manifest content
Condensation	Several ideas combined into one image
Displacement	Emotional significance shifted from one object to another
Symbolization	Abstract ideas represented by concrete images
Secondary revision	Reorganising the dream into a coherent narrative

NOTE Dream-work transforms latent (hidden wish) into manifest (remembered) content through condensation, displacement, symbolization, and secondary revision - dreams being 'the royal road to the unconscious'.

ATTACHMENT THEORY (COMPREHENSIVE)

Attachment theory - Bowlby and Ainsworth, the attachment classifications, the Strange Situation, and related concepts. A key developmental topic.

Attachment Classifications

Type	Features & Caregiver Pattern
Secure (Type B)	~55-65%; distressed at separation, comforted at reunion; caregiver sensitive/responsive
Insecure-avoidant (Type A)	~20%; minimal distress at separation, avoids caregiver at reunion; caregiver rejecting/intrusive
Insecure-ambivalent/resistant (Type C)	~10-15%; intense distress, hard to soothe, angry/clingy at reunion; caregiver inconsistent
Disorganized (Type D)	~5-10%; contradictory, fearful, freezing behaviours; linked to maltreatment/frightening caregiver (Main & Solomon)

NOTE Ainsworth's Strange Situation yields three organised patterns (secure B, avoidant A, ambivalent C); Main & Solomon later added the DISORGANIZED type (D), strongly linked to maltreatment and frightening caregiving.

Key Concepts & Figures

Concept / Figure	Contribution
John Bowlby	Founder; attachment is a biological/evolutionary need; 'maternal deprivation'; internal working models; monotropy
Mary Ainsworth	The 'Strange Situation' procedure (12 months); identified secure/avoidant/ambivalent types; maternal sensitivity hypothesis
Strange Situation	Structured lab observation of separations & reunions to classify attachment
Internal working model	Mental representation of self, others, and relationships built from early attachment
Monotropy	Bowlby's idea of a primary attachment figure

Concept / Figure	Contribution
Critical/sensitive period	Bowlby proposed attachment must form within ~2.5 years
Harry Harlow	Rhesus monkeys preferred a cloth 'mother' over a wire feeding one - contact comfort over feeding
Adult Attachment Interview (AAI)	Classifies adult states of mind: secure-autonomous, dismissing, preoccupied, unresolved
Mentalization (Fonagy)	Capacity to understand behaviour in terms of mental states; develops via secure attachment
Reactive attachment disorder	Inhibited, emotionally withdrawn pattern from grossly inadequate care; 'frozen watchfulness'

NOTE Harlow's rhesus monkeys chose a cloth surrogate 'mother' over a wire one that provided food - demonstrating that **CONTACT COMFORT**, not feeding, drives attachment, contradicting the cupboard-love theory.

DEVELOPMENTAL MILESTONES (COMPREHENSIVE)

Normal child developmental milestones across gross motor, fine motor, and language/social domains - capturing the standard sequence. A key child development topic; ages are averages and slight variation is normal.

Gross Motor

Age	Milestone
6 weeks	Lifts head briefly when prone
3 months	Holds head steady; supports on forearms when prone
6 months	Sits with support; rolls over; no head lag on pulling to sit
9 months	Sits unsupported; crawls; pulls to stand
12 months	Stands alone; walks with one hand held; cruises
15 months	Walks independently; climbs stairs on hands & knees
18 months	Runs; walks up stairs with hand held
2 years	Walks up & down stairs (two feet per step); kicks a ball; runs well

Age	Milestone
3 years	Stairs adult-fashion going up; rides a tricycle; stands on one foot briefly
4 years	Hops on one foot; stairs adult-fashion down; climbs
5 years	Skips; catches a ball

NOTE Key gross-motor anchors: head control by 3 months, sits unsupported by 6-9 months, walks independently by ~12 months (refer if not walking by 18 months), and stairs adult-fashion by 3 years.

Fine Motor & Vision

Age	Milestone
6 weeks	Follows object/face through 90 degrees; fixes & follows
3 months	Holds object placed in hand; hands open
6 months	Palmar grasp; transfers objects hand to hand; reaches
9-10 months	Immature pincer grip; points with index finger
12 months	Mature (neat) pincer grip; casting
18 months	Tower of 3-4 cubes; scribbles; turns several pages
2 years	Tower of 6-7 cubes; imitates vertical line; turns pages singly
3 years	Tower of 9 cubes; copies a circle; draws a person (head + ~1 part)
4 years	Copies a cross; draws a person with head, trunk, legs
5 years	Copies a square & triangle; draws a recognisable person

NOTE The pincer grip matures from an immature form (~9-10 months) to a neat pincer (~12 months); the cube tower (3 at 18 months, 6 at 2 years, 9 at 3 years) and shape-copying (circle 3, cross 4, square 5) are classic test items.

Language & Social

Age	Milestone
6 weeks	Social smile (by 6 weeks); startles to noise
3 months	Vocalises/coos; laughs
6 months	Babbles (consonant sounds); turns to voice

Age	Milestone
9 months	'Mama/dada' non-specific; stranger anxiety; waves bye-bye
12 months	1-2 words with meaning; understands simple commands; object permanence
18 months	6-20 words; points to body parts; uses spoon
2 years	2-word phrases; ~50 words; parallel play; symbolic play
3 years	3-word sentences; knows name/age/sex; toilet trained by day; cooperative play
4 years	Tells stories; counts; understands turn-taking; imaginative play
5 years	Fluent speech; knows colours; fully intelligible; has friends

NOTE Social smile appears by 6 weeks (a key early milestone), first meaningful words by ~12 months, 2-word phrases by 2 years, and fully intelligible speech by ~4 years - refer if no words by 18 months or no phrases by 2.5 years.

PIAGET, ERIKSON & KOHLBERG STAGES (COMPREHENSIVE)

The three classic stage theories of development - Piaget (cognitive), Erikson (psychosocial), and Kohlberg (moral). A key developmental psychology topic.

Piaget - Cognitive Development

Stage	Features
Sensorimotor (0-2 yr)	Learns through senses/movement; OBJECT PERMANENCE develops (~8 months); circular reactions; stranger anxiety
Preoperational (2-7 yr)	Symbolic thought, language; EGOCENTRISM; animism; lack of CONSERVATION; centration; magical thinking
Concrete operational (7-11 yr)	Logical thinking about concrete objects; conservation achieved; reversibility; classification; decentration
Formal operational (11+ yr)	Abstract & hypothetical reasoning; deductive logic; systematic problem-solving

NOTE Piaget's signatures: object permanence (sensorimotor), egocentrism and lack of conservation (preoperational), conservation and reversibility (concrete operational), and abstract reasoning (formal operational).

Erikson - Psychosocial Stages

Stage (Virtue)	Theme
Trust vs mistrust (0-1 yr)	Hope; quality of caregiving
Autonomy vs shame/doubt (1-3 yr)	Will; toilet training, independence
Initiative vs guilt (3-6 yr)	Purpose; exploration, play
Industry vs inferiority (6-12 yr)	Competence; school, skills
Identity vs role confusion (12-18 yr)	Fidelity; adolescent identity formation
Intimacy vs isolation (young adult)	Love; relationships
Generativity vs stagnation (middle age)	Care; contributing to society/next generation
Ego integrity vs despair (old age)	Wisdom; life review & acceptance

NOTE Erikson's eight stages each pair a crisis with a virtue; the adolescent stage (identity vs role confusion -> fidelity) and the final stage (ego integrity vs despair -> wisdom) are the most frequently tested.

Kohlberg - Moral Development

Level / Stage	Orientation
Pre-conventional - Stage 1	Obedience & punishment orientation (avoid punishment)
Pre-conventional - Stage 2	Instrumental/self-interest ('what's in it for me?')
Conventional - Stage 3	Interpersonal conformity ('good boy/girl', seeking approval)
Conventional - Stage 4	Authority & social-order ('law and order')
Post-conventional - Stage 5	Social contract & individual rights

Level / Stage	Orientation
Post-conventional - Stage 6	Universal ethical principles (conscience)

NOTE Kohlberg's three levels (pre-conventional, conventional, post-conventional) progress from avoiding punishment, through law-and-order conformity, to universal ethical principles - though most adults reach only the conventional level.

GROUP THERAPY & YALOM'S FACTORS (COMPREHENSIVE)

Group psychotherapy - Yalom's eleven therapeutic factors and key group-therapy concepts and figures. A key psychotherapy topic.

Yalom's Therapeutic Factors

Factor	Description
Instillation of hope	Seeing others improve gives hope for one's own recovery
Universality	Realising one is not alone in one's problems ('we're all in the same boat')
Imparting information	Didactic instruction and advice about mental health
Altruism	Gaining self-esteem through helping others in the group
Corrective recapitulation of the primary family group	Re-experiencing and resolving family conflicts within the group
Development of socializing techniques	Learning basic social skills through group interaction
Imitative behaviour	Modelling on the therapist or other members
Interpersonal learning	Gaining insight into one's interpersonal style via feedback; the group as a 'social microcosm'
Group cohesiveness	The sense of belonging and acceptance - the group analogue of the therapeutic alliance
Catharsis	Emotional release of feelings within a supportive setting
Existential factors	Accepting responsibility, mortality, and life's ultimate aloneness

NOTE Yalom's eleven therapeutic factors are the classic list; **UNIVERSALITY** (not being alone) and **INTERPERSONAL LEARNING** (the group as a 'social microcosm') are among the most emphasised, with group cohesiveness as the group analogue of the therapeutic alliance.

Key Concepts & Figures

Concept / Figure	Contribution
Ideal group size	~7-8 members (range 5-10) for interpersonal group therapy
Foulkes	Founder of group analysis; 'the group matrix'; the conductor
Bion	Basic assumption groups: dependency, fight-flight, pairing (vs the work group)
Therapeutic community	Maxwell Jones; the whole milieu as treatment; democratization, permissiveness, communalism, reality confrontation
Slavson	Pioneer of analytic group psychotherapy
Closed vs open group	Fixed membership vs members joining/leaving over time

NOTE Bion's 'basic assumption' groups (dependency, fight-flight, pairing) describe unconscious group processes that oppose the rational 'work group' - a frequently tested group-dynamics concept.

RECEPTOR BINDING PROFILES (COMPREHENSIVE)

The receptor binding profiles of antipsychotics and antidepressants, and how they explain efficacy and side effects - capturing the key agents. A key psychopharmacology topic.

Antipsychotic Receptor Profiles

Drug	Profile & Consequences
Haloperidol	Potent D2 antagonist; minimal anticholinergic/antihistaminic -> high EPSE, low sedation/weight gain
Chlorpromazine	D2 + strong H1, M1, alpha-1 -> sedation, weight gain, anticholinergic, postural hypotension

Drug	Profile & Consequences
Clozapine	Weak D2, high D4, 5-HT2A, M1 (but hypersalivation via M4 agonism), H1, alpha-1 -> minimal EPSE, agranulocytosis, seizures, weight gain
Olanzapine	D2, 5-HT2A, H1 (strong), M1 -> marked weight gain & metabolic effects, sedation
Risperidone	D2 + 5-HT2A + alpha-1 -> dose-dependent EPSE & hyperprolactinaemia (highest prolactin of atypicals), postural hypotension
Quetiapine	Weak D2, 5-HT2A, strong H1, alpha-1 -> low EPSE, sedation, postural hypotension; norquetiapine is an NRI (antidepressant action)
Aripiprazole	D2 & D3 PARTIAL agonist + 5-HT1A partial agonist + 5-HT2A antagonist -> low prolactin/EPSE, akathisia, activation
Amisulpride	Selective D2/D3 (presynaptic at low dose); no 5-HT2A action -> hyperprolactinaemia; renally excreted
Ziprasidone/Lurasidone	D2 + 5-HT2A + 5-HT1A; minimal weight gain; ziprasidone QT risk; lurasidone akathisia

NOTE Receptor profile predicts side effects: D2 potency -> EPSE & prolactin (haloperidol, risperidone, amisulpride); H1 -> sedation & weight gain (olanzapine, clozapine, quetiapine); M1 -> anticholinergic; alpha-1 -> postural hypotension.

NOTE Aripiprazole's D2 PARTIAL agonism makes it a 'dopamine stabiliser' with low prolactin and low EPSE but prominent akathisia/activation - mechanistically distinct from all pure D2 antagonists.

Antidepressant Receptor Profiles

Drug	Profile & Consequences
SSRIs	Selective serotonin reuptake inhibition; paroxetine has anticholinergic & short half-life; citalopram QT
TCAs	5-HT + NA reuptake inhibition PLUS H1 (sedation), M1 (anticholinergic), alpha-1 (postural hypotension), Na-channel (cardiotoxic in overdose)

Drug	Profile & Consequences
Venlafaxine/Duloxetine	SNRI - 5-HT + NA reuptake (NA at higher doses for venlafaxine); raised BP
Mirtazapine	alpha-2 antagonist (boosts NA & 5-HT) + 5-HT ₂ /5-HT ₃ + strong H ₁ -> sedation, weight gain, low nausea/sexual dysfunction
Trazodone	5-HT ₂ antagonist + weak SERT + alpha-1 + H ₁ -> sedation, priapism risk
Bupropion	NA + DA reuptake inhibition (NDRI); low sexual dysfunction; lowers seizure threshold
Vortioxetine	SERT inhibition + 5-HT ₃ antagonist + 5-HT _{1A} agonist (multimodal); pro-cognitive
Agomelatine	MT ₁ /MT ₂ agonist + 5-HT _{2C} antagonist; hepatotoxicity monitoring
MAOIs	Inhibit monoamine oxidase (irreversible/non-selective: phenelzine; reversible MAO-A: moclobemide) -> tyramine reaction

NOTE TCAs' 'dirty' profile explains their toxicity: beyond 5-HT/NA reuptake block, they hit H₁ (sedation), M₁ (anticholinergic), alpha-1 (hypotension), and cardiac Na channels (fatal in overdose).

SIDE EFFECTS BY DRUG CLASS (COMPREHENSIVE)

A systematic reference to the characteristic side effects of each psychotropic drug class - capturing the full landscape. Confirm specifics against the current BNF.

Side Effects by Class

Drug Class	Characteristic Side Effects
Typical antipsychotics	EPSE (dystonia, akathisia, parkinsonism, tardive dyskinesia), hyperprolactinaemia, NMS, QT prolongation, anticholinergic, sedation

Drug Class	Characteristic Side Effects
Atypical antipsychotics	Metabolic syndrome (weight gain, dyslipidaemia, diabetes), sedation, less EPSE; clozapine: agranulocytosis, myocarditis, seizures, hypersalivation, ileus
SSRIs	Nausea/GI, sexual dysfunction, insomnia/agitation, hyponatraemia/SIADH, GI bleeding, discontinuation syndrome, QT (citalopram)
SNRIs	As SSRIs plus raised BP, sweating; venlafaxine marked discontinuation
TCA's	Anticholinergic (dry mouth, constipation, retention, blurred vision), postural hypotension, sedation, weight gain, cardiotoxicity (lethal in overdose), lowered seizure threshold
MAOIs	Hypertensive 'cheese' crisis (tyramine), postural hypotension, serotonin syndrome, weight gain, insomnia, hepatotoxicity
Lithium	Tremor, polyuria/polydipsia (nephrogenic DI), hypothyroidism, weight gain, GI upset, cognitive dulling, teratogenicity (Ebstein's), long-term renal impairment
Valproate	Weight gain, tremor, hair loss, hepatotoxicity, pancreatitis, thrombocytopenia, teratogenicity (NTD, low IQ), PCOS
Carbamazepine	SJS/TEN (HLA-B*1502), agranulocytosis/aplastic anaemia, hyponatraemia (SIADH), enzyme induction, ataxia, diplopia
Lamotrigine	Rash/Stevens-Johnson syndrome (slow titration), headache, dizziness; few metabolic effects
Benzodiazepines	Sedation, dependence/tolerance, falls, anterograde amnesia, respiratory depression, paradoxical disinhibition
Stimulants	Appetite/weight loss, insomnia, raised HR/BP, tics, growth suppression, dependence
Cholinesterase inhibitors	GI (nausea, vomiting, diarrhoea), bradycardia/syncope, insomnia/vivid dreams, muscle cramps

NOTE The atypical antipsychotics trade EPSE for METABOLIC side effects - weight gain, dyslipidaemia, and diabetes - with olanzapine and clozapine the worst offenders and aripiprazole, ziprasidone, and lurasidone the most weight-neutral.

NOTE Three anticonvulsant mood stabilisers carry signature dermatological/haematological risks: carbamazepine (SJS/TEN, agranulocytosis), lamotrigine (SJS - hence slow titration), and valproate (thrombocytopenia, hepatotoxicity).

DISCONTINUATION & WITHDRAWAL SYNDROMES (COMPREHENSIVE)

Discontinuation and withdrawal syndromes of psychotropic drugs - their features, timing, and management. A key prescribing-safety topic.

Discontinuation Syndromes by Drug

Drug	Syndrome & Features
SSRI/SNRI discontinuation	FINISH: Flu-like, Insomnia, Nausea, Imbalance, Sensory disturbances ('brain zaps'), Hyperarousal/anxiety; onset within days, worst with short half-life (paroxetine, venlafaxine), least with fluoxetine
TCA discontinuation	Cholinergic rebound: GI upset, flu-like symptoms, insomnia, movement disorders, cardiac
MAOI discontinuation	Agitation, psychosis, cognitive impairment; can be severe
Benzodiazepine withdrawal	Rebound anxiety/insomnia, tremor, perceptual disturbance, seizures, delirium (can be fatal); worse with short-acting
Antipsychotic discontinuation	Cholinergic rebound, dyskinesias (withdrawal/rebound), insomnia, nausea; rapid relapse risk
Lithium discontinuation	Rebound mania; rapid discontinuation raises relapse risk - taper slowly over weeks
Clozapine discontinuation	Rapid (rebound) psychosis & cholinergic rebound; especially severe - avoid abrupt cessation
Stimulant withdrawal	Fatigue, hypersomnia, hyperphagia, dysphoria ('crash'), vivid dreams

Drug	Syndrome & Features
General principle	Discontinuation symptoms are NOT addiction; minimise by gradual tapering; distinguish from relapse (later onset, original symptoms)

NOTE The SSRI/SNRI discontinuation mnemonic FINISH (Flu-like, Insomnia, Nausea, Imbalance, Sensory disturbances, Hyperarousal) is worst with short-half-life agents (paroxetine, venlafaxine) and least with long-half-life fluoxetine.

NOTE Distinguish discontinuation from relapse: discontinuation symptoms are early (within days), often physical/novel ('brain zaps'), and resolve quickly on restarting - whereas relapse is later and reproduces the original illness.

DEPOT / LONG-ACTING ANTIPSYCHOTICS (COMPREHENSIVE)

Long-acting injectable (depot) antipsychotics - agents, dosing intervals, and principles of use. A key prescribing topic.

Depot / LAI Agents & Intervals

Agent	Interval & Notes
Haloperidol decanoate	Every 4 weeks; test dose; typical antipsychotic depot
Flupentixol decanoate	Every 2-4 weeks; may have mood-elevating effect
Zuclopenthixol decanoate	Every 2-4 weeks; useful in agitation/aggression
Fluphenazine decanoate	Every 2-5 weeks; high EPSE risk
Pipotiazide palmitate	Every 4 weeks
Risperidone (Risperdal Consta)	Every 2 weeks; needs oral cover for first 3 weeks; first atypical LAI
Paliperidone palmitate (Xeplion)	Monthly; no oral cover needed; loading on days 1 & 8 (deltoid)
Paliperidone (Trevicta)	Every 3 MONTHS (after stabilisation on monthly)
Olanzapine pamoate	Every 2-4 weeks; risk of post-injection delirium/sedation syndrome - 3-hour observation required

Agent	Interval & Notes
Aripiprazole (Maintena)	Monthly; needs 14-day oral overlap
Aripiprazole lauroxil	Every 4-8 weeks

NOTE Two atypical LAI specifics recur: Risperdal Consta needs 3 weeks of oral cover (delayed release), whereas paliperidone palmitate needs none; paliperidone Trevicta extends dosing to every 3 months.

Principles of Depot Use

Principle	Detail
Main advantage	Assured adherence/compliance - no covert non-adherence; reduced relapse; avoids first-pass metabolism
Main disadvantages	Less dose flexibility, slow to adjust, injection-site pain, perceived coercion, delayed offset if side effects occur
Test dose	Required for oil-based typical depots (delayed reaction risk)
Z-track technique	Used for deep IM injection to reduce leakage & irritation
Olanzapine pamoate caution	Post-injection syndrome (delirium/sedation) in ~0.07% of injections - 3 h observation mandatory

NOTE Olanzapine pamoate carries a unique post-injection delirium/sedation syndrome (~0.07% of injections) requiring 3 hours of post-injection observation - a frequently tested safety point.

SEROTONIN SYNDROME vs NMS (COMPREHENSIVE)

A side-by-side comparison of serotonin syndrome and neuroleptic malignant syndrome - two life-threatening drug emergencies that are frequently confused. A key emergency topic.

Serotonin Syndrome vs NMS

Feature	Serotonin Syndrome	NMS
Onset	Rapid (<24 h, often within hours)	Slow (days to weeks)

Feature	Serotonin Syndrome	NMS
Cause	Serotonergic excess (SSRIs, MAOIs, combinations)	Dopamine (D2) blockade (antipsychotics) or DA withdrawal
Neuromuscular	Hyperreactivity: clonus (esp. lower limb), hyperreflexia, myoclonus, tremor	'Lead-pipe' rigidity, bradyreflexia, akinesia
Mental state	Agitation, hypomania, confusion	Stupor, mutism, coma
Pupils	Mydriasis (dilated)	Normal
Bowel sounds	Hyperactive, diarrhoea	Normal or decreased
Temperature	Raised (can be >41.1 in severe)	High fever (hyperthermia)
CK	Usually normal/mildly raised	Markedly raised; raised WCC; low serum iron
Resolution	Usually <24 h after stopping agent	Days to weeks (long-acting)
Treatment	Stop agent, supportive, benzodiazepines, cyproheptadine	Stop antipsychotic, supportive, dantrolene, bromocriptine

NOTE The fastest discriminators: serotonin syndrome causes hyperREACTIVITY (clonus, hyperreflexia, mydriasis, hyperactive bowel sounds) and onsets within hours, whereas NMS causes hypoREACTIVITY ('lead-pipe' rigidity, bradyreflexia) and onsets over days.

NOTE Treatment differs: serotonin syndrome responds to cyproheptadine (5-HT_{2A} antagonist), while NMS responds to dantrolene and bromocriptine - both need the offending drug stopped plus aggressive supportive care and cooling.

LITHIUM - COMPLETE MONOGRAPH (COMPREHENSIVE)

A complete reference to lithium - indications, mechanism, levels, side effects, toxicity, teratogenicity, and monitoring. Lithium has a narrow therapeutic index and is one of the most important drugs in psychiatry. Confirm all figures against the current BNF.

Lithium - Key Facts

Topic	Detail
Indications	Acute mania, bipolar prophylaxis (best evidence), augmentation in resistant depression, reduces suicidality

Topic	Detail
Mechanism	Inhibits inositol monophosphatase (inositol depletion) & GSK-3; modulates glutamate, PKC, neuroprotective (raises BDNF)
Therapeutic range	0.6-1.0 mmol/L maintenance; 0.8-1.2 acute mania; sample 12 h post-dose
Toxic level	>1.5 mmol/L (mild-moderate); >2.0-2.5 severe (dialysis)
Excretion	Almost entirely renal; NOT metabolised; reabsorbed with sodium (low Na -> retention/toxicity)
Half-life	~18-24 h (longer in elderly/renal impairment)
Early side effects	Fine tremor, polyuria/polydipsia, nausea, metallic taste, loose stools, weight gain
Long-term effects	Hypothyroidism (women 14%), nephrogenic diabetes insipidus, reduced renal function, hyperparathyroidism/hypercalcaemia, weight gain, cognitive dulling
Toxicity features	Coarse tremor, ataxia, dysarthria, drowsiness, confusion, vomiting/diarrhoea, nystagmus, seizures, coma, renal failure
Toxicity precipitants	Dehydration, NSAIDs, ACE inhibitors/ARBs, thiazide diuretics, low sodium, renal impairment, drug interactions
Teratogenicity	Ebstein's anomaly (~1:1000; 20-40x baseline); 'floppy baby'; neonatal goitre; stop 1-2 days pre-delivery
Monitoring	Levels every 3 months (then 6); U&E, eGFR, TFTs, calcium every 6 months; pregnancy test; ECG if cardiac risk
Toxicity management	Stop lithium, IV normal saline, monitor levels/U&E, haemodialysis if >2.5 or severe symptoms
Narrow therapeutic index	Small gap between therapeutic and toxic - the reason for mandatory monitoring

NOTE Lithium is renally excreted and reabsorbed alongside sodium, so anything causing sodium depletion or reduced renal clearance - dehydration, NSAIDs, ACE inhibitors, thiazides, low-salt diets - precipitates toxicity.

NOTE Distinguish side effects from toxicity by the tremor: a FINE tremor is an expected side effect, but a COARSE tremor with ataxia, dysarthria, and drowsiness signals toxicity (>1.5 mmol/L) and demands urgent action.

NEUROTRANSMITTER PATHWAYS (COMPREHENSIVE)

The major neurotransmitter pathways of the brain and their clinical relevance - dopamine, serotonin, noradrenaline, acetylcholine, GABA, glutamate, and more. A key neuroscience topic.

Dopamine Pathways

Pathway	Origin -> Target & Relevance
Mesolimbic	VTA -> nucleus accumbens/limbic; HYPERactivity = positive symptoms of psychosis; reward & addiction pathway
Mesocortical	VTA -> prefrontal cortex; HYPOactivity = negative & cognitive symptoms
Nigrostriatal	Substantia nigra -> striatum; D2 blockade = EPSE (Parkinsonism, dystonia, TD); degenerates in Parkinson's
Tuberoinfundibular	Hypothalamus -> pituitary; dopamine tonically INHIBITS prolactin; D2 blockade = hyperprolactinaemia

NOTE The four dopamine pathways explain antipsychotic action and side effects: blocking mesolimbic D2 is therapeutic (positive symptoms), but the same blockade in the nigrostriatal (EPSE), mesocortical (worsened negative symptoms), and tuberoinfundibular (hyperprolactinaemia) pathways causes side effects.

Other Neurotransmitter Systems

System	Origin & Relevance
Serotonin (5-HT)	Raphe nuclei (brainstem) -> widespread cortex/limbic; mood, sleep, appetite, anxiety; low in depression/suicide
Noradrenaline (NA)	Locus coeruleus (pons) -> widespread; arousal, attention, fight-or-flight, mood
Acetylcholine - basal forebrain	Nucleus basalis of Meynert -> cortex/hippocampus; memory; degenerates in Alzheimer's
Acetylcholine - brainstem	Pedunculopontine -> thalamus; arousal, REM sleep

System	Origin & Relevance
GABA	Main INHIBITORY transmitter; cortical interneurons; targeted by benzodiazepines, alcohol, barbiturates
Glutamate	Main EXCITATORY transmitter; NMDA receptor; implicated in schizophrenia (hypofunction) & excitotoxicity
Histamine	Tuberomammillary nucleus -> widespread; wakefulness; H1 blockade = sedation/weight gain
Orexin (hypocretin)	Lateral hypothalamus; wakefulness; deficient in narcolepsy with cataplexy

NOTE Know the origin nuclei: serotonin from the raphe nuclei, noradrenaline from the locus coeruleus, acetylcholine (memory) from the nucleus basalis of Meynert, and histamine from the tuberomammillary nucleus.

BRAIN LESIONS & SYNDROMES (COMPREHENSIVE)

Localisation of brain lesions to their clinical syndromes - lobe by lobe and structure by structure. A key neuropsychiatry topic.

Lesion -> Syndrome

Region	Syndrome / Features
Dominant (left) parietal lobe	Gerstmann syndrome: dysgraphia, dyscalculia, finger agnosia, left-right disorientation; receptive dysphasia
Non-dominant (right) parietal lobe	Hemineglect, anosognosia, dressing/constructional apraxia, prosopagnosia
Temporal lobe	Memory impairment, auditory hallucinations, complex partial seizures, Wernicke's (receptive) aphasia, Kluver-Bucy (bilateral)
Occipital lobe	Cortical blindness (Anton's syndrome - denial of blindness), visual agnosia, visual hallucinations
Frontal lobe	Personality change, disinhibition or apathy, executive dysfunction, expressive (Broca's) aphasia, primitive reflexes, perseveration

Region	Syndrome / Features
Corpus callosum	Disconnection syndromes; Marchiafava-Bignami disease (alcohol)
Thalamus	Amnesia (dorsomedial nucleus), sensory loss, thalamic pain
Hypothalamus	Appetite, temperature, sleep, endocrine disturbance; Kleine-Levin
Basal ganglia	Movement disorders, OCD, apathy; Huntington's (caudate), Parkinson's (substantia nigra)
Amygdala (bilateral)	Kluver-Bucy: hyperorality, hypersexuality, placidity, visual agnosia, hypermetamorphosis
Mammillary bodies / dorsomedial thalamus	Wernicke-Korsakoff (thiamine deficiency); anterograde amnesia & confabulation
Cerebellum	Ataxia, dysarthria (scanning speech), nystagmus, intention tremor; 'cognitive-affective syndrome'
Dominant frontal (Broca's area)	Expressive (non-fluent) aphasia - effortful speech, intact comprehension
Dominant temporal (Wernicke's area)	Receptive (fluent) aphasia - fluent but meaningless speech, impaired comprehension

NOTE Gerstmann syndrome (dysgraphia, dyscalculia, finger agnosia, left-right disorientation) localises to the DOMINANT parietal lobe; the non-dominant parietal lobe instead produces neglect, anosognosia, and dressing apraxia.

NOTE Distinguish the aphasias: Broca's (dominant frontal) is expressive/non-fluent with preserved comprehension, while Wernicke's (dominant temporal) is receptive/fluent with impaired comprehension.

FRONTAL LOBE SYNDROMES (COMPREHENSIVE)

The three classic frontal lobe syndromes, their localisation, and tests of frontal function - capturing the full picture. A key neuropsychiatry topic.

Frontal Lobe Syndromes

Syndrome	Localisation & Features
Dorsolateral prefrontal syndrome	DYSEXECUTIVE: poor planning, working memory, set-shifting, abstraction, perseveration, reduced verbal fluency; 'pseudodepression'
Orbitofrontal syndrome	DISINHIBITED: impulsivity, emotional lability, poor judgement, social inappropriateness, 'pseudopsychopathic'; utilisation behaviour
Medial frontal / anterior cingulate syndrome	APATHETIC/AKINETIC: abulia, apathy, reduced spontaneity, akinetic mutism (severe), incontinence
Frontal release signs	Grasp, pout, palmomentary, glabellar tap, sucking reflexes - reappear with frontal pathology
Phineas Gage	Classic case - orbitofrontal damage producing profound personality change with preserved intellect
Tests of frontal function	Wisconsin Card Sort, verbal fluency (FAS), Stroop, Trail-making B, proverb interpretation, cognitive estimates, Luria sequences
Utilisation behaviour	Compulsive use of objects placed within reach - environmental dependency (frontal)
Primary motor / Broca's	Contralateral weakness; expressive aphasia (dominant)

NOTE The three frontal syndromes map to three regions: dorsolateral (dysexecutive, 'pseudodepressed'), orbitofrontal (disinhibited, 'pseudopsychopathic'), and medial/anterior cingulate (apathetic/akinetic).

NOTE Frontal lobe function is tested with the Wisconsin Card Sort (set-shifting), verbal fluency (FAS), Stroop, Trail-making B, proverb interpretation, and Luria motor sequences.

MEMORY SYSTEMS & AMNESIAS (COMPREHENSIVE)

The taxonomy of memory and the amnesic syndromes - capturing the systems, their neuroanatomy, and the classic disorders. A key neuropsychology topic.

Memory Systems & Amnesias

System / Disorder	Features
Sensory memory	Very brief (<1 s) iconic/echoic store

System / Disorder	Features
Short-term / working memory	Seconds-minutes; capacity $\sim 7 \pm 2$ (Miller); Baddeley's model (central executive, phonological loop, visuospatial sketchpad, episodic buffer); prefrontal cortex
Long-term - declarative (explicit)	Conscious facts & events; EPISODIC (events; hippocampus) & SEMANTIC (facts; temporal cortex)
Long-term - non-declarative (implicit)	PROCEDURAL (skills; basal ganglia & cerebellum), priming, classical conditioning - spared in amnesia
Anterograde amnesia	Inability to form NEW memories after the insult (hippocampal/medial temporal damage)
Retrograde amnesia	Loss of memories BEFORE the insult; often a temporal gradient (recent more affected - Ribot's law)
Korsakoff's syndrome	Profound anterograde amnesia + confabulation; thiamine deficiency; mammillary bodies/dorsomedial thalamus
Transient global amnesia	Sudden, isolated anterograde amnesia for hours with repetitive questioning; benign, resolves
Dissociative (psychogenic) amnesia	Loss of autobiographical/personal memory after stress; may include identity (fugue); procedural memory intact
Patient H.M.	Bilateral medial temporal lobectomy -> severe anterograde amnesia with intact procedural learning; defined the role of the hippocampus
Confabulation	Fabricated memories with no intent to deceive (provoked/momentary vs spontaneous/fantastic)

NOTE Procedural (implicit) memory - skills, supported by the basal ganglia and cerebellum - is characteristically SPARED in amnesic syndromes, which is why patient H.M. could learn new motor skills despite dense anterograde amnesia.

NOTE Korsakoff's syndrome pairs profound anterograde amnesia with confabulation, localising to the mammillary bodies and dorsomedial thalamus from thiamine deficiency.

EEG & SLEEP STAGES (COMPREHENSIVE)

EEG waveforms and the stages of sleep - their frequencies, features, and clinical relevance. A key basic-sciences topic.

EEG Waveforms

Wave (Frequency)	Associations
Beta (>13 Hz)	Alert, eyes open, concentration; benzodiazepines & barbiturates increase beta
Alpha (8-13 Hz)	Relaxed, awake, eyes closed; posterior dominant rhythm
Theta (4-7 Hz)	Drowsiness, N1 sleep, children; abnormal if prominent in awake adult
Delta (<4 Hz)	Deep (N3) slow-wave sleep; pathological when awake (e.g. delirium, tumour)

NOTE EEG frequency mnemonic (fastest to slowest): Beta (alert) > Alpha (relaxed, eyes closed) > Theta (drowsy) > Delta (deep sleep) - 'BATD'. Benzodiazepines and barbiturates increase beta activity.

Sleep Stages

Stage	Features
N1 (NREM)	Light sleep; theta; ~5%; loss of alpha, slow rolling eye movements; hypnic jerks
N2 (NREM)	~45-55% (largest); sleep spindles & K-complexes; theta
N3 (NREM) - slow-wave	Deep sleep; delta waves; ~15-20%; growth hormone release; night terrors, sleepwalking, enuresis arise here; declines with age
REM sleep	~20-25%; low-voltage mixed-frequency (sawtooth) waves; atonia; dreaming; nightmares; penile tumescence; ~90-min cycles, increasing toward morning
Sleep architecture changes (depression)	Reduced REM latency, increased REM density, reduced slow-wave sleep, early waking
Narcolepsy	Sleep-onset REM periods (SOREMPs); reduced REM latency

NOTE Sleep spindles and K-complexes define N2 (the largest stage); slow-wave N3 hosts the NREM parasomnias (night terrors, sleepwalking, enuresis) and growth-hormone release; REM brings atonia, dreaming, and nightmares.

DESCRIPTIVE PSYCHOPATHOLOGY (COMPREHENSIVE)

The core terms of descriptive psychopathology (phenomenology, after Jaspers and Sims) - perception, thought, mood, and disorders of the self. A key phenomenology topic.

Disorders of Perception

Term	Definition
Illusion	Misperception of a real external stimulus
Hallucination	Perception without an external stimulus, experienced as real & in external space
Pseudohallucination	Perceived in inner subjective space, insight relatively retained
Functional hallucination	Stimulus and hallucination in the same modality (e.g. voices only when a tap runs)
Reflex hallucination	Stimulus in one modality triggers hallucination in another
Extracampine hallucination	Perceived outside the sensory field (e.g. voices from another country)
Hypnagogic / hypnopompic	On falling asleep / on waking - normal phenomena
Autoscopy	Seeing oneself ('phantom mirror image')

NOTE Distinguish a pseudohallucination (experienced in INNER subjective space with retained insight) from a true hallucination (experienced in EXTERNAL space as real); a functional hallucination requires a real stimulus in the SAME modality to trigger it.

Disorders of Thought Content

Term	Definition
Overvalued idea	A comprehensible, strongly held belief, not as fixed as a delusion, pursued beyond reason
Obsession	Recurrent, intrusive, ego-dystonic thought, resisted, recognised as one's own
Delusion	Fixed, false belief, out of keeping with culture, held with absolute conviction

Term	Definition
Compulsion	Repetitive behaviour/mental act in response to an obsession
Phobia	Persistent irrational fear with avoidance, recognised as excessive

NOTE An overvalued idea sits between a normal belief and a delusion - it is comprehensible and not bizarre, but is pursued beyond reason (seen in anorexia, morbid jealousy, hypochondriasis).

Disorders of Mood & Affect

Term	Definition
Affect vs mood	Affect = momentary/observed emotional state; mood = sustained/pervasive ('climate vs weather')
Blunted/flat affect	Reduced/absent emotional expression
Incongruent affect	Emotional expression at odds with content
Labile affect	Rapid, abrupt shifts in emotion
Alexithymia	Difficulty identifying & describing one's own emotions
Anhedonia	Inability to experience pleasure
Apathy	Lack of interest, emotion, or motivation

NOTE Affect is the immediate, observable emotional state ('weather'); mood is the sustained, pervasive emotional climate ('climate') - a distinction examiners frequently probe.

Disorders of the Self

Term	Definition
Depersonalization	Feeling detached/unreal in oneself
Derealization	The external world feels unreal
Made experiences (passivity)	Feelings/impulses/acts experienced as externally controlled (first-rank)

DELUSIONS - TYPES & EPONYMS (COMPREHENSIVE)

The types of delusion and the named delusional syndromes (eponyms) - capturing the full classic set. A key phenomenology topic.

Types & Eponymous Delusions

Delusion	Description
Persecutory (paranoid)	Belief of being harmed/conspired against - the commonest type
Grandiose	Inflated worth, power, identity (mania, GPI)
Reference	Neutral events/objects refer specifically to oneself
Nihilistic	Belief that oneself/part of body/the world is dead or non-existent (Cotard's)
Hypochondriacal	Belief of having a serious illness
Guilt/poverty	Belief of having sinned/being destitute (depression)
Religious	Belief with religious content
Jealousy (Othello syndrome)	Delusion that a partner is unfaithful; forensic risk
Erotomania (de Clerambault)	Belief that another (often of higher status) is in love with oneself
Infestation (Ekbom)	Delusional parasitosis - belief of being infested with parasites
Misidentification - Capgras	Belief that a familiar person has been replaced by an identical impostor
Misidentification - Fregoli	Belief that strangers are a familiar persecutor in disguise
Intermetamorphosis	Belief that people swap identities with each other
Folie a deux	Shared delusion (induced/communicated) in a close relationship
Primary (autochthonous) delusion	Arises fully formed without antecedent (delusional perception, intuition, mood, memory)
Delusional perception	A real perception given a delusional meaning (first-rank symptom)

NOTE Know the delusional misidentification pair: Capgras (a familiar person replaced by an identical IMPOSTOR) versus Fregoli (a familiar persecutor DISGUISED as strangers).

NOTE Eponymous delusions cluster: Othello (infidelity), de Clerambault/erotomania (being loved by another), Cotard (nihilistic - being dead), and Ekbom (infestation/parasitosis).

HALLUCINATIONS - TYPES (COMPREHENSIVE)

The types of hallucination across sensory modalities and their diagnostic significance - capturing the full set. A key phenomenology topic.

Types of Hallucination

Type	Description
Auditory - 2nd person	Voices addressing the patient directly ('you are...')
Auditory - 3rd person	Voices discussing the patient ('he is...') - first-rank
Running commentary	Voice narrating the patient's actions - first-rank
Thought echo (echo de la pensee)	Hearing one's thoughts spoken aloud - first-rank (Gedankenlautwerden)
Visual	More suggestive of organic/drug causes; Charles Bonnet (eye disease, insight intact)
Olfactory/gustatory	Smell/taste; temporal lobe epilepsy, depression (unpleasant)
Tactile (haptic)	Touch; formication ('cocaine bugs') in stimulant use/withdrawal
Somatic/visceral	Hallucinations from inside the body
Lilliputian	Seeing miniature figures (delirium tremens) - often pleasurable
Hypnagogic/hypnopompic	On falling asleep/waking; narcolepsy; not pathological alone
Command hallucinations	Voices instructing action; risk assessment important

NOTE Three auditory hallucinations are Schneiderian first-rank symptoms: third-person voices, running commentary, and thought echo (hearing one's own thoughts aloud).

NOTE Modality hints at cause: prominent VISUAL, olfactory, or tactile hallucinations suggest an ORGANIC or drug-related cause rather than primary psychosis - e.g. Lilliputian hallucinations in delirium tremens, formication in stimulant use.

THOUGHT & SPEECH DISORDERS (COMPREHENSIVE)

Disorders of the form of thought and speech, and disorders of the possession of thought - capturing the full descriptive set. A key phenomenology topic.

Disorders of Thought Form & Speech

Term	Definition
Circumstantiality	Over-inclusive detail but eventually reaches the point
Tangentiality	Wanders off and never returns to the point
Flight of ideas	Rapid stream with discernible connections (puns, clang, rhyme); mania
Loosening of associations (knight's move)	Illogical jumps between unrelated ideas; schizophrenia
Word salad (schizophasia)	Incomprehensible mixture of words & phrases
Perseveration	Inappropriate repetition of a previous response; organic/frontal
Neologism	A newly coined word or ordinary word used in a private way
Echolalia	Repetition of the examiner's words
Palilalia	Repetition of one's own last word/phrase, increasing in frequency
Logoclonia	Repetition of the last syllable of a word
Verbigeration	Senseless repetition of words/phrases
Thought block	Sudden cessation of the flow of thought; schizophrenia
Pressure of speech	Rapid, increased, hard-to-interrupt speech; mania
Poverty of speech (alogia)	Reduced amount/content; negative symptom
Clang association	Words chosen for sound (rhyme/pun) not meaning
Concrete thinking	Loss of abstraction (e.g. literal proverb interpretation)

NOTE Distinguish the three 'going off topic' terms: circumstantiality (eventually returns to the point), tangentiality (never returns), and loosening of associations/knight's move (illogical jumps - characteristic of schizophrenia).

NOTE Flight of ideas (mania) retains discernible connections (puns, rhymes, clang), whereas loosening of associations (schizophrenia) has no logical thread - a key differentiating point.

Disorders of Thought Possession

Term	Definition
Thought insertion	Belief that thoughts are placed into one's mind by an external agency (first-rank)
Thought withdrawal	Belief that thoughts are removed from one's mind (first-rank)
Thought broadcasting	Belief that one's thoughts are accessible to others (first-rank)
Obsessional thoughts	Recognised as one's own (vs alien in passivity phenomena)

NOTE Thought insertion, withdrawal, and broadcasting are all Schneiderian first-rank symptoms; the alien quality (thoughts felt as not one's own) distinguishes them from obsessions, which are always recognised as self-generated.

FIRST-RANK SYMPTOMS (SCHNEIDER) (COMPREHENSIVE)

Schneider's first-rank symptoms of schizophrenia - the full list, their grouping, and their diagnostic significance. A key phenomenology topic.

Schneider's First-Rank Symptoms

Symptom	Description
Auditory - thought echo	Hearing thoughts spoken aloud (Gedankenlautwerden / echo de la pensee)
Auditory - third person	Voices discussing/arguing about the patient in the third person
Auditory - running commentary	Voices giving a running commentary on the patient's actions
Thought insertion	Thoughts inserted by an external force

Symptom	Description
Thought withdrawal	Thoughts taken away by an external force
Thought broadcasting	Thoughts diffuse out and are shared by others
Made feelings (affect)	Emotions imposed by an external agency
Made impulses (drive)	Impulses imposed by an external agency
Made acts (volition)	Actions experienced as controlled by an external agency (passivity)
Somatic passivity	Bodily sensations imposed by an external agency
Delusional perception	A real perception given a delusional significance (2-stage)

NOTE The first-rank symptoms fall into three groups: specific auditory hallucinations (thought echo, third-person voices, running commentary), thought alienation (insertion/withdrawal/broadcasting), and passivity phenomena (made acts/feelings/impulses, somatic passivity) plus delusional perception.

Significance & Caveats

Point	Detail
Significance	Highly suggestive of (but not pathognomonic for) schizophrenia if organic cause excluded; present in ~70% of schizophrenia
Not specific	Can occur in mania, psychotic depression, organic states - so not diagnostic alone
DSM-5 change	DSM-5 removed the special weighting of first-rank symptoms (one FRS no longer sufficient)
The three groups	(1) Auditory hallucinations, (2) thought alienation, (3) passivity/made phenomena + delusional perception

NOTE First-rank symptoms are suggestive but NOT pathognomonic - they occur in mania, psychotic depression, and organic states - and DSM-5 removed their special diagnostic weighting.

CATATONIA - SIGNS (COMPREHENSIVE)

The motor signs of catatonia, the diagnostic lorazepam challenge, and the main causes - capturing the full set. A key phenomenology and emergency topic.

Catatonic Signs

Sign	Description
Stupor	Unresponsiveness/immobility with preserved consciousness
Catalepsy / waxy flexibility	Limbs held in imposed postures (cerea flexibilitas)
Posturing	Spontaneous maintenance of unusual postures
Negativism	Motiveless resistance to instructions or attempts to move
Mutism	Absence of speech
Mannerisms	Odd, purposeful movements (the commonest catatonic sign per Abrams & Taylor)
Stereotypies	Repetitive, non-goal-directed movements
Echolalia / echopraxia	Imitation of speech / movements
Automatic obedience	Exaggerated cooperation with instructions
Ambitendency	Alternating between cooperation and resistance
Mitgehen	Excessive movement in response to light pressure ('anglepoise lamp')
Gegenhalten	Resistance proportional to the force applied
Grimacing	Maintenance of odd facial expressions
Waxy flexibility	Initial resistance then maintenance of an imposed posture
Excitement	Purposeless, agitated motor activity (excited catatonia)
Lorazepam challenge	Diagnostic & therapeutic - >80% respond to IV lorazepam
Causes	Mood disorders (commonest), schizophrenia, organic/medical (encephalitis, metabolic); malignant catatonia overlaps NMS

NOTE Mannerisms (odd, purposeful movements) were the commonest catatonic sign in Abrams & Taylor's series, followed by stereotypies, stupor, and negativism; waxy flexibility (cerea flexibilitas) is the classic but not the most frequent sign.

NOTE The lorazepam challenge is both diagnostic and therapeutic - over 80% of catatonia responds rapidly to IV lorazepam; ECT is used for refractory or malignant catatonia, which clinically overlaps with NMS.

FORENSIC PSYCHIATRY (COMPREHENSIVE)

Core forensic psychiatry concepts - fitness to plead, the insanity defence, diminished responsibility, and risk assessment. Reflects UK/common-law frameworks; confirm against local law. A key forensic topic.

Forensic Concepts

Concept	Definition
Fitness to plead (Pritchard criteria)	Ability to: understand the charge, understand plea options, instruct a lawyer, challenge a juror, follow court proceedings; (Scotland adds give evidence)
M'Naghten Rules (insanity)	At the time, due to a defect of reason from disease of mind, the defendant did not know the nature/quality of the act, OR did not know it was wrong
Diminished responsibility	Abnormality of mental functioning (from a recognised condition) substantially impairing ability to understand conduct/form judgement/exercise self-control; reduces murder to manslaughter
Automatism	Involuntary act; insane (internal cause - e.g. epilepsy) vs non-insane (external - e.g. hypoglycaemia)
Mens rea / actus reus	Guilty mind / guilty act - both usually required for a crime
Infanticide	Mother kills child <12 months while balance of mind disturbed by birth/lactation; treated as manslaughter
Actuarial vs structured clinical risk	Actuarial tools (Static-99, VRAG) vs structured professional judgement (HCR-20)
Static vs dynamic risk factors	Static (unchangeable - past violence, age at first offence) vs dynamic (modifiable - substance use, symptoms)
Best predictor of future violence	Past violence (history of violence)
MacArthur violence risk study	Substance misuse a key mediator; mental illness alone a modest risk factor
Homicide-suicide (dyadic death)	Often depression; perpetrator usually male; victim usually partner/family

Concept	Definition
Hospital order (MHA s37/41)	Court-ordered detention for treatment; s41 adds a restriction order

NOTE The M'Naghten Rules define legal insanity: a defect of reason from disease of mind such that the person did not know the NATURE/QUALITY of the act, or did not know it was WRONG.

NOTE The single best predictor of future violence is a PAST history of violence; the MacArthur study highlighted substance misuse as a key mediator, with mental illness alone only a modest risk factor.

MENTAL CAPACITY & CONSENT (COMPREHENSIVE)

The assessment of mental capacity, valid consent, and related legal frameworks - reflecting the Mental Capacity Act model. Confirm against local law. A key medico-legal topic.

Capacity & Consent

Concept	Detail
Capacity - 4 components (MCA)	Ability to: UNDERSTAND the information, RETAIN it, USE/WEIGH it, COMMUNICATE the decision
Presumption of capacity	Adults assumed to have capacity unless proven otherwise
Decision-specific & time-specific	Capacity is assessed for a particular decision at a particular time (not global)
Unwise decisions	A capacitous person may make an unwise decision - this alone does not indicate incapacity
Best interests	Decisions for those lacking capacity made in their best interests, least restrictive option
Valid consent (3 elements)	Informed, capacitous, and voluntary (free from coercion)
Gillick competence / Fraser guidelines	A child under 16 may consent if they have sufficient understanding & intelligence
Advance decision	A capacitous person's prior refusal of specified treatment, binding if valid & applicable
Lasting power of attorney	Appointed decision-maker for health/welfare when capacity is lost

Concept	Detail
Deprivation of Liberty Safeguards (DoLS)	Legal framework for depriving an incapacitated person of liberty in their best interests
MCA vs MHA	Mental Capacity Act for incapacity generally; Mental Health Act for detention/treatment of mental disorder

NOTE Capacity has four components: UNDERSTAND, RETAIN, USE/WEIGH, and COMMUNICATE - failure of ANY one means the person lacks capacity for that specific decision at that time.

NOTE A capacitous patient may make an UNWISE decision - this alone does not indicate incapacity; capacity is decision-specific and time-specific, never global.

ETHICAL PRINCIPLES & DILEMMAS (COMPREHENSIVE)

The core principles and theories of medical ethics and their application in psychiatry - capturing the full framework. A key ethics topic.

Ethical Principles & Theories

Principle / Theory	Definition
Autonomy	Respecting the patient's right to self-determination and informed choice
Beneficence	Acting in the patient's best interest / doing good
Non-maleficence	'First, do no harm' (primum non nocere)
Justice	Fairness in distribution of resources & treatment (Beauchamp & Childress 'four principles')
Confidentiality	Duty to protect patient information; may be breached if risk of serious harm (Tarasoff - duty to warn)
Consequentialism / utilitarianism	Morality judged by outcomes (greatest good for the greatest number)
Deontology	Morality based on duties & rules (Kant) regardless of consequences
Virtue ethics	Focus on the character of the moral agent (Aristotle)

Principle / Theory	Definition
Double effect	An act with a good intended effect may be permissible despite a foreseen bad effect (e.g. palliative sedation)
Paternalism	Overriding autonomy for the patient's perceived good; generally limited to incapacity/risk
Capacity & consent	Cornerstones of autonomy in practice
Tarasoff principle	Duty to protect identifiable third parties from a dangerous patient

NOTE Beauchamp & Childress's 'four principles' - autonomy, beneficence, non-maleficence, and justice - form the standard framework for analysing clinical ethical dilemmas.

NOTE Distinguish the three normative theories: consequentialism (judge by outcomes), deontology (judge by duties/rules - Kant), and virtue ethics (judge by the agent's character - Aristotle).

STATISTICS & RESEARCH METHODS (COMPREHENSIVE)

Research study designs, types of bias, and core statistical concepts - the foundation of critical appraisal.
A key research-methods topic.

Study Designs

Design	Features
Randomised controlled trial (RCT)	Gold standard for causation; randomisation controls confounding; blinding reduces bias
Cohort study	Prospective; follows exposed vs unexposed; yields incidence & relative risk; good for rare exposures
Case-control study	Retrospective; compares cases vs controls; yields odds ratio; good for rare diseases; prone to recall bias
Cross-sectional study	Snapshot in time; yields prevalence; cannot establish causation
Systematic review / meta-analysis	Highest level of evidence; pools studies; forest plot, heterogeneity (I-squared)
Case report / series	Lowest level; hypothesis-generating

Design	Features
Ecological study	Population-level; risk of ecological fallacy

NOTE Match design to measure: cohort/RCT yield relative risk and incidence (prospective), case-control yields the odds ratio (retrospective, good for rare diseases), and cross-sectional yields prevalence.

Types of Bias

Bias	Description
Selection bias	Non-representative sampling (e.g. Berkson's, healthy-worker effect)
Recall bias	Differential recollection between groups (esp. case-control)
Observer/measurement bias	Systematic error in assessment; reduced by blinding
Confounding	A third variable associated with both exposure & outcome; controlled by randomisation, matching, stratification, regression
Lead-time bias	Earlier detection appears to prolong survival without changing outcome
Publication bias	Positive studies more likely published; detected by funnel plot asymmetry
Attrition bias	Differential dropout between groups
Hawthorne effect	Behaviour changes from being observed

NOTE Confounding (a third variable linked to both exposure and outcome) is controlled at the DESIGN stage by randomisation and matching, and at the ANALYSIS stage by stratification and regression - distinct from bias, which is a systematic error.

Statistical Concepts

Concept	Definition
Type I error (alpha)	False positive - rejecting a true null hypothesis (conventionally 5%)
Type II error (beta)	False negative - failing to reject a false null hypothesis

Concept	Definition
Power (1 - beta)	Probability of detecting a true effect; increased by larger samples (conventionally 80%)
p-value	Probability of the observed result (or more extreme) if the null were true; <0.05 conventionally significant
Confidence interval	Range likely to contain the true value; if a 95% CI for RR/OR crosses 1, not significant
Relative risk vs odds ratio	RR from cohort/RCT; OR from case-control; OR approximates RR for rare outcomes
NNT	Number needed to treat = 1/absolute risk reduction
Number needed to harm	1/absolute risk increase

NOTE Type I error (alpha, false positive) versus Type II error (beta, false negative); statistical power (1 - beta) is the ability to detect a true effect and is increased mainly by larger sample sizes.

VALIDITY & RELIABILITY (COMPREHENSIVE)

The psychometric concepts of validity and reliability, and the diagnostic-test measures derived from them - capturing the full set. A key research-methods topic.

Reliability & Validity

Concept	Definition
Reliability (definition)	Consistency/reproducibility of a measure
Inter-rater reliability	Agreement between different raters (kappa statistic)
Test-retest reliability	Consistency over time on repeat administration
Internal consistency	Items measure the same construct (Cronbach's alpha)
Split-half reliability	Correlation between two halves of a test
Validity (definition)	Whether a test measures what it claims to measure
Face validity	Appears to measure the construct (superficial)
Content validity	Covers the full range of the construct

Concept	Definition
Construct validity	Measures the theoretical construct (convergent & divergent)
Criterion validity	Agreement with a gold standard - concurrent (now) or predictive (future)
Sensitivity	Proportion of true positives correctly identified (SnNOUT - high Sn, Negative rules OUT)
Specificity	Proportion of true negatives correctly identified (SpPIN - high Sp, Positive rules IN)
Positive predictive value	Proportion of positives that are true (depends on prevalence)
Negative predictive value	Proportion of negatives that are true (depends on prevalence)
Kappa	Chance-corrected agreement; >0.8 very good, 0.6-0.8 good, <0.2 poor

NOTE Reliability is consistency; validity is accuracy - a test can be reliable (consistent) without being valid (correct), but it cannot be valid without being reliable.

NOTE Two diagnostic-test mnemonics: SnNOUT (a highly SENSITIVE test, when Negative, rules OUT) and SpPIN (a highly SPECIFIC test, when Positive, rules IN); predictive values, unlike sensitivity/specificity, depend on prevalence.

EPIDEMIOLOGY CONCEPTS (COMPREHENSIVE)

Core epidemiological measures and concepts - incidence, prevalence, risk measures, and mortality ratios.
A key research-methods topic.

Epidemiological Measures

Concept	Definition
Incidence	Number of NEW cases in a population over a time period (rate)
Prevalence	Number of EXISTING cases at a point (point) or over a period (period)

Concept	Definition
Prevalence = incidence x duration	Chronic disorders have high prevalence relative to incidence
Point prevalence	Cases at a single point in time
Period/lifetime prevalence	Cases over an interval / over the whole lifetime
Morbid risk (lifetime expectancy)	Probability of developing a disorder over a lifetime
Relative risk	Risk in exposed / risk in unexposed (cohort/RCT)
Odds ratio	Odds of exposure in cases / in controls (case-control)
Attributable risk	Risk difference attributable to the exposure
Standardised mortality ratio (SMR)	Observed / expected deaths x 100
Absolute risk reduction	Difference in event rates between groups
Incidence vs prevalence in psychiatry	Schizophrenia: low incidence, moderate prevalence (chronicity); depression: high incidence & prevalence

NOTE The key relationship is $\text{prevalence} = \text{incidence} \times \text{duration}$: chronic disorders (like schizophrenia) accumulate a high prevalence relative to their incidence, while brief disorders do not.

NOTE Match the risk measure to the design: relative risk from cohort studies and RCTs, odds ratio from case-control studies (where the OR approximates the RR when the outcome is rare).

EPONYMOUS SYNDROMES (COMPREHENSIVE)

Eponymous (named) syndromes across psychiatry and neuropsychiatry - capturing the classic set. A key rapid-recognition topic.

Eponymous Syndromes

Syndrome	Features
Capgras syndrome	Familiar person replaced by an impostor (delusional misidentification)
Fregoli syndrome	A persecutor disguised as various strangers

Syndrome	Features
Cotard syndrome	Nihilistic delusion of being dead/non-existent
Othello syndrome	Delusional jealousy of infidelity
de Clerambault syndrome	Erotomania - belief one is loved by another
Ekbom syndrome	Delusional parasitosis (also = restless legs eponym)
Ganser syndrome	Approximate answers (vorbeigehen), clouding, somatic conversion, pseudohallucinations
Couvade syndrome	Sympathetic pregnancy symptoms in the partner
Munchausen syndrome	Factitious disorder imposed on self
Kluver-Bucy syndrome	Hyperorality, hypersexuality, placidity, visual agnosia (bilateral temporal)
Charles Bonnet syndrome	Complex visual hallucinations with insight in the visually impaired
Kleine-Levin syndrome	Periodic hypersomnia, hyperphagia, hypersexuality
Wernicke-Korsakoff syndrome	Thiamine deficiency: confusion/ataxia/ophthalmoplegia then amnesia/confabulation
Gerstmann syndrome	Dysgraphia, dyscalculia, finger agnosia, left-right disorientation (dominant parietal)
Geschwind syndrome	Interictal TLE: hyperreligiosity, hypergraphia, hyposexuality, viscosity
De Fombelle / Diogenes syndrome	Senile squalor - extreme self-neglect, hoarding, social withdrawal
Othello / morbid jealousy	Forensic risk; associated with alcohol
Briquet syndrome	Somatization disorder
Capgras vs Fregoli	Impostor (Capgras) vs disguise (Fregoli)
Folie a deux (Lasegue-Falret)	Shared delusional disorder
Tourette syndrome	Multiple motor + ≥ 1 vocal tic > 1 year, onset < 18

NOTE The delusional misidentification syndromes are a favourite cluster: Capgras (impostor), Fregoli (disguise), Cotard (nihilistic/dead), and intermetamorphosis (identity-swapping).

NOTE Ganser syndrome (a dissociative disorder) is characterised by approximate answers (vorbeigehen) - e.g. answering '5' to '2+2' - alongside clouding of consciousness and pseudohallucinations.

MNEMONICS COLLECTION (COMPREHENSIVE)

A collection of key psychiatry mnemonics - for diagnosis, screening, side effects, and classification. A practical revision aid.

Psychiatry Mnemonics

Mnemonic	Expansion
SIGECAPS	Depression: Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicide
DIGFAST	Mania: Distractibility, Indiscretion, Grandiosity, Flight of ideas, Activity, Sleep decrease, Talkativeness
DEAD SWAMP	PTSD-style cluster aide-memoire (varies by source)
CAGE	Alcohol: Cut down, Annoyed, Guilty, Eye-opener
FRAMES	Brief intervention: Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy
FINISH	SSRI discontinuation: Flu-like, Insomnia, Nausea, Imbalance, Sensory disturbance, Hyperarousal
3 Ws	Normal pressure hydrocephalus: Wobbly, Wet, Wacky
WWHHHHIMPS	Causes of delirium (Wernicke's, Withdrawal, Hypoxia, Hyper/hypoglycaemia, Hypertensive crisis, Hyper/hypothermia, Intracranial, Meningitis, Poisons, Status epilepticus)
ABCD2	(General) stroke risk - context for vascular cognitive disorders
Cluster A/B/C	PD clusters: A (odd - paranoid, schizoid, schizotypal), B (dramatic - antisocial, borderline, histrionic, narcissistic), C (anxious - avoidant, dependent, obsessive-compulsive)
Mad/Bad/Sad clusters	Informal aide for Cluster A/B/C

Mnemonic	Expansion
CAM (4 features)	Delirium: acute onset & fluctuation, inattention, disorganised thinking, altered consciousness
GET SMASHED	Causes of pancreatitis (relevant to valproate/alcohol)

NOTE The two mood-episode mnemonics anchor diagnosis: **SIGECAPS** (≥ 5 for a depressive episode) and **DIGFAST** ($\geq 3-4$ for a manic episode).

NOTE The personality-disorder clusters: **A** (odd/eccentric - paranoid, schizoid, schizotypal), **B** (dramatic/erratic - antisocial, borderline, histrionic, narcissistic), **C** (anxious/fearful - avoidant, dependent, obsessive-compulsive).

EMERGENCY PSYCHIATRY PROTOCOLS (COMPREHENSIVE)

Management of psychiatric and psychopharmacological emergencies - capturing the key protocols. Confirm against current local guidelines before use. A key emergency topic.

Emergency Protocols

Emergency	Management
Acute behavioural disturbance / rapid tranquillisation	De-escalation first; then oral, then IM lorazepam or IM antipsychotic (haloperidol + promethazine, or olanzapine); monitor vitals; flumazenil/procyclidine available
Acute dystonia	IM/IV anticholinergic (procyclidine/benztropine) - rapid relief
Neuroleptic malignant syndrome	Stop antipsychotic, supportive/cooling, IV fluids, dantrolene, bromocriptine; ECT if refractory
Serotonin syndrome	Stop serotonergics, supportive, benzodiazepines, cyproheptadine, cooling
Lithium toxicity	Stop lithium, IV saline, monitor levels/U&E, haemodialysis if severe
Delirium tremens	Benzodiazepines (chlordiazepoxide/diazepam), parenteral thiamine (before glucose), supportive; treat cause
Wernicke's encephalopathy	IV/IM high-dose thiamine BEFORE carbohydrate; treat as emergency

Emergency	Management
Clozapine agranulocytosis	Stop immediately, haematology referral, G-CSF, reverse isolation, never rechallenge
Acute akathisia	Reduce dose; propranolol; benzodiazepine
Opioid overdose	Naloxone (short-acting - monitor for re-narcotisation), airway/ventilation support
Catatonia	Lorazepam challenge; ECT for refractory/malignant catatonia
Status epilepticus (drug-induced)	Benzodiazepines first-line; address cause

NOTE Rapid tranquillisation follows a hierarchy: de-escalation first, then oral medication, then IM (lorazepam, or haloperidol with promethazine, or olanzapine) - with flumazenil and procyclidine on hand for adverse effects.

NOTE Thiamine must be given parenterally and BEFORE any glucose in suspected Wernicke's or delirium tremens - a carbohydrate load can precipitate or worsen Wernicke's encephalopathy.

NMS, SEROTONIN SYNDROME & CATATONIA - MANAGEMENT (COMPREHENSIVE)

Recognition and management protocols for the movement-disorder emergencies - NMS, serotonin syndrome, catatonia, and tardive dyskinesia. Confirm against current guidelines. A key emergency topic.

Recognition & Management Protocols

Condition	Recognition / Management
NMS - recognition	Tetrad: hyperthermia, 'lead-pipe' rigidity, autonomic instability, altered consciousness; raised CK/WCC, low iron
NMS - management	Stop antipsychotic, ICU supportive care + cooling + IV fluids; dantrolene (muscle relaxant), bromocriptine/amantadine (dopamine agonists); benzodiazepines; ECT if refractory; restart antipsychotic cautiously after ≥ 2 weeks (low-potency/different class)

Condition	Recognition / Management
Serotonin syndrome - recognition	Triad: neuromuscular hyperactivity (clonus, hyperreflexia), autonomic instability, altered mental state; rapid onset
Serotonin syndrome - management	Stop serotonergic agents, supportive care, benzodiazepines for agitation/clonus, cyproheptadine (5-HT _{2A} antagonist), active cooling; usually resolves <24 h
Catatonia - management	Lorazepam challenge (1-2 mg IV) - >80% respond; lorazepam trial; ECT for refractory or malignant catatonia; treat underlying cause; AVOID antipsychotics in malignant catatonia (NMS risk)
Tardive dyskinesia - management	Reduce/stop offending agent, switch to clozapine/quetiapine; VMAT2 inhibitors (valbenazine, deutetrabenazine, tetrabenazine); avoid anticholinergics (worsen TD)
Acute dystonia - management	IM/IV procyclidine or benztropine; rapid response; reduce antipsychotic
Akathisia - management	Reduce dose; propranolol first-line; benzodiazepine; consider switch/clonidine; mirtazapine
Lithium toxicity - management	Stop lithium, IV normal saline to restore volume & sodium, serial levels, haemodialysis if >2.5 mmol/L or severe symptoms
Malignant catatonia vs NMS	Clinically overlapping; both have rigidity, hyperthermia, autonomic instability; benzodiazepines/ECT central to catatonia, dantrolene/bromocriptine to NMS

NOTE NMS and malignant catatonia overlap clinically (rigidity, hyperthermia, autonomic instability); antipsychotics are AVOIDED in malignant catatonia, where benzodiazepines and ECT are central, whereas NMS is managed with dantrolene and bromocriptine.

NOTE Avoid anticholinergics in tardive dyskinesia (they worsen it); the evidence-based treatments are VMAT2 inhibitors (valbenazine, deutetrabenazine) and switching to clozapine or quetiapine.

TIME TO EFFICACY / ONSET OF ACTION (COMPREHENSIVE)

How long psychotropic medications take to work - onset and time to maximal efficacy by drug class. A practical reference for setting expectations and timing review. Confirm against current prescribing information.

Onset & Time to Maximal Efficacy

Drug / Class	Onset & Time Course
Antidepressants (overall)	2-6 weeks for maximum efficacy (up to 12 weeks); some symptoms improve in first 1-2 weeks (sleep, appetite, energy) before mood; early switching rarely beats waiting
Mirtazapine	May act slightly faster than other antidepressants (the one consistent exception), at the cost of greater weight gain/sedation
Antipsychotics - typical (1-2 days)	Hyperactivity, combativeness, hostility, agitation settle first
Antipsychotics - typical (1-2 weeks)	Hallucinations, sleep, appetite, hygiene, delusions, social engagement improve
Antipsychotics - typical (1-2 months)	Judgement and insight are the last to improve
Antipsychotics - atypical	Negative symptoms and cognition may take months to respond
Benzodiazepines	Onset 10 min - 1-2 h (absorption-dependent); rapid: diazepam, clorazepate, alprazolam; intermediate: chlordiazepoxide, lorazepam; slow: oxazepam, temazepam, clonazepam
Buspirone	Anxiolytic onset 1-2 weeks (5-HT _{1A} partial agonist); NOT a PRN drug
Lithium	Onset 7-14 days; maximal antimanic efficacy ~1 month
Valproate / Carbamazepine	Onset within several days to weeks; maximal when steady-state levels reach upper therapeutic range
Acute mania (comparative)	Antipsychotics act faster than mood stabilisers; efficacy order risperidone > olanzapine > haloperidol (68-RCT meta-analysis)

Drug / Class	Onset & Time Course
Stimulants (ADHD)	Rapid - response within 15-30 min, lasting 2-12 h orally
Atomoxetine / non-stimulants	Onset may take 3-4 weeks
Ketamine (IV, depression)	Rapid onset (hours) - studied for treatment-resistant depression

NOTE Antidepressants take 2-6 weeks (up to 12) for full effect; some neurovegetative symptoms (sleep, appetite, energy) improve first, while mood and the risk of acting on suicidal thoughts may lag - hence close early monitoring.

NOTE Typical antipsychotics improve symptoms in a predictable sequence: agitation/hostility within 1-2 days, hallucinations and delusions over 1-2 weeks, and judgement/insight only after 1-2 months.

NOTE In acute mania, antipsychotics work faster than mood stabilisers, with a meta-analytic efficacy order of risperidone > olanzapine > haloperidol.

BLOOD ALCOHOL CONCENTRATION (BAC) EFFECTS (COMPREHENSIVE)

The clinical effects of alcohol at rising blood alcohol concentrations, from mild disinhibition to fatal respiratory arrest. Effects vary with tolerance and biological sensitivity; $BAC \% \times 1000 = mg/dL$.

Effects by Blood Alcohol Concentration

BAC % (mg/dL)	Clinical Effects
0.02-0.03% (20-30)	Mild loss of coordination, slight euphoria, loss of shyness; depressant effects not yet apparent
0.04-0.06% (40-60)	Well-being, relaxation, lowered inhibitions, warmth; minor impairment of reasoning & memory; emotions intensified
0.07-0.09% (70-90)	Slight impairment of balance, speech, vision, reaction time, hearing; 0.08% = legal driving limit; overestimates own ability
0.10-0.125% (100-125)	Significant motor incoordination, loss of judgement; slurred speech; impaired balance/vision/reaction
0.13-0.15% (130-150)	Gross motor impairment, blurred vision, major loss of balance; euphoria fades, dysphoria (anxiety/restlessness) begins
0.16-0.19% (160-190)	Dysphoria predominates, nausea may appear; 'sloppy drunk' appearance

BAC % (mg/dL)	Clinical Effects
0.20% (200)	Dazed/confused/disoriented; needs help to stand or walk; nausea & vomiting; impaired gag reflex (choking risk); blackouts likely
0.25% (250)	All mental, physical, and sensory functions severely impaired; high asphyxiation & injury risk
0.30% (300)	STUPOR; little comprehension of surroundings; may pass out, difficult to rouse
0.35% (350)	Coma possible; equivalent to the level of surgical anaesthesia
0.40%+ (>400)	Onset of coma; possible death from respiratory arrest

NOTE 0.08% (80 mg/dL) is the legal driving limit in many jurisdictions; at this level judgement and self-control are reduced while the person typically believes they are performing better than they are.

NOTE Blackouts become likely around 0.20%, surgical-anaesthesia-level coma around 0.35%, and respiratory arrest with possible death above 0.40% - though tolerance shifts these thresholds substantially in chronic drinkers.

URINE DRUG DETECTION WINDOWS (COMPREHENSIVE)

Approximate urine detection windows for drugs of misuse - useful for interpreting drug screens. Figures are estimates; actual windows vary with metabolism, dose, duration of use, hydration, laboratory, and assay threshold.

Detection Windows by Substance

Substance	Approximate Urine Detection Window
Alcohol	~7-12 hours (longer with EtG/EtS testing: up to ~80 h)
Amphetamines / methamphetamine	~2-3 days (up to 4)
Barbiturates - short-acting	~2-4 days
Barbiturates - long-acting (phenobarbital)	Up to ~2-3 weeks
Benzodiazepines - short-acting	~3 days
Benzodiazepines - long-acting	Up to ~30 days (chronic use)

Substance	Approximate Urine Detection Window
Cocaine (benzoylecgonine)	~2-4 days (up to ~1 week in heavy use)
Cannabis - single use	~2-3 days
Cannabis - chronic / heavy use	Up to ~30 days (fat-soluble, accumulates)
Opioids (heroin/morphine/codeine)	~2-3 days
Methadone	~3 days (up to ~1 week)
Buprenorphine	~3-7 days
Oxycodone	~2-4 days
Phencyclidine (PCP)	~1 week (up to ~30 days in chronic use)
MDMA / ecstasy	~2-4 days
LSD	~1-3 days (often not detected on routine screens)

NOTE Chronic cannabis use has by far the longest cannabinoid window (up to ~30 days) because THC is fat-soluble and accumulates - whereas single use clears in ~2-3 days.

NOTE Benzodiazepine and barbiturate windows depend heavily on half-life: short-acting agents clear in days, but long-acting ones (chronic benzodiazepines, phenobarbital) remain detectable for up to ~2-4 weeks.

OPIOID EQUIANALGESIC DOSING (COMPREHENSIVE)

Approximate equianalgesic doses of opioids, referenced to 10 mg parenteral (30 mg oral) morphine. For revision only - always use a conservative conversion with dose reduction for incomplete cross-tolerance, and seek specialist advice for methadone. N = natural, SS = semi-synthetic, S = synthetic.

Equianalgesic Doses (ref: morphine 10 mg IV / 30 mg PO)

Opioid	Equianalgesic Dose & Notes
Morphine (oral)	30 mg PO = 10 mg IV/IM (reference standard); N (natural)
Morphine (parenteral)	10 mg IV/IM (the equianalgesic reference)
Codeine (oral)	~200 mg PO ~ 30 mg oral morphine; N (natural)

Opioid	Equianalgesic Dose & Notes
Hydrocodone (oral)	~30 mg PO ~ 30 mg oral morphine; SS (semi-synthetic)
Oxycodone (oral)	~20 mg PO ~ 30 mg oral morphine; SS
Hydromorphone (oral / IV)	~7.5 mg PO or ~1.5 mg IV ~ 10 mg IV morphine; SS
Oxymorphone (oral / IV)	~10 mg PO or ~1 mg IV; SS
Fentanyl (parenteral)	~100 micrograms IV ~ 10 mg IV morphine (~100x more potent); S (synthetic)
Methadone (oral)	Highly variable, dose-dependent ratio (NOT linear) - specialist conversion only; S
Meperidine/pethidine (oral / IV)	~300 mg PO or ~75 mg IV; toxic metabolite normeperidine (seizures); S
Tramadol (oral)	~120 mg PO ~ 30 mg oral morphine (weak); S; serotonergic
Buprenorphine	Partial agonist; ~0.3 mg IM; ceiling effect on respiratory depression; SS
Tapentadol (oral)	~75-100 mg PO; dual mu-agonist + NRI; S

NOTE Fentanyl is roughly 100 times more potent than morphine (100 micrograms IV ~ 10 mg IV morphine); methadone conversion is non-linear and dose-dependent, so it must never be converted with a simple ratio.

NOTE When rotating opioids, reduce the calculated equianalgesic dose by 25-50% to account for incomplete cross-tolerance - and remember meperidine/pethidine's metabolite normeperidine accumulates and causes seizures.

ANTIPSYCHOTIC COMPARATIVE RISK RANKINGS (COMPREHENSIVE)

Side-by-side risk rankings of antipsychotics for the four side effects that drive drug choice - metabolic, QTc, prolactin, and EPS. A practical prescribing reference; rankings are approximate and overlap.

Metabolic Syndrome Risk

Tier	Agents
------	--------

Tier	Agents
Highest metabolic risk	Clozapine, Olanzapine (most weight gain, diabetes, dyslipidaemia)
Intermediate	Quetiapine, Risperidone, Paliperidone, Asenapine, Iloperidone
Lowest metabolic risk	Aripiprazole, Ziprasidone, Lurasidone (most weight-neutral)
Consensus guidance	If diabetes or significant weight gain develops, switch toward ziprasidone or aripiprazole
Baseline diabetes risk	2-4x the non-psychiatric population (~13%) across antipsychotic-treated patients

NOTE Metabolic risk runs highest with clozapine and olanzapine and lowest with aripiprazole, ziprasidone, and lurasidone - so consensus guidance is to switch toward ziprasidone or aripiprazole if diabetes or weight gain emerges.

QTc Prolongation Risk

Aspect	Detail
QTc prolongation (high to low)	Mesoridazine > thioridazine > ziprasidone > iloperidone > haloperidol > quetiapine > clozapine > risperidone > asenapine > olanzapine > paliperidone > aripiprazole > lurasidone
Highest-risk typicals	Thioridazine & mesoridazine (both carry QTc black-box warnings)
Highest-risk atypical	Ziprasidone (take with food; avoid other QT-prolonging drugs); iloperidone also notable
Lowest-risk atypicals	Aripiprazole, lurasidone, paliperidone
Threshold values	High QTc: >450 ms (men), >470 ms (women); prolonged QT raises risk of torsades de pointes & sudden death

NOTE For QTc, the thioridazine/mesoridazine typicals top the list (black-box warnings), and ziprasidone leads the atypicals - while aripiprazole and lurasidone are among the safest.

Prolactin Elevation Risk

Aspect	Detail
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Aspect	Detail
Prolactin elevation (high to low)	Paliperidone > risperidone > haloperidol (and other typicals) > olanzapine > quetiapine = ziprasidone = asenapine = lurasidone = iloperidone = aripiprazole = clozapine
Highest	Paliperidone & risperidone (dose-related hyperprolactinaemia)
Prolactin-sparing	Aripiprazole (partial agonist - may LOWER prolactin), quetiapine, clozapine
Consequences	Galactorrhoea, amenorrhoea, gynaecomastia, sexual dysfunction, osteoporosis

NOTE Paliperidone and risperidone cause the most hyperprolactinaemia, whereas aripiprazole (a partial agonist) can actually LOWER prolactin - a useful switch when hyperprolactinaemia is problematic.

Dose-Related EPS Risk

Aspect	Detail
Dose-related EPS (high to low)	Risperidone = paliperidone > olanzapine = ziprasidone = aripiprazole > quetiapine = clozapine
Highest EPS (atypicals)	Risperidone, paliperidone (dose-dependent)
Lowest EPS	Clozapine and quetiapine (preferred in Parkinson's/Lewy body disease)
Typical antipsychotics	High-potency (haloperidol, fluphenazine) - high EPS; low-potency (chlorpromazine, thioridazine) - low EPS but high anticholinergic/sedation/hypotension

NOTE Risperidone and paliperidone carry the most dose-related EPS among atypicals; clozapine and quetiapine carry the least, making them the agents of choice in Parkinson's disease and Lewy body dementia.

TYPICAL ANTIPSYCHOTIC POTENCY EQUIVALENTS (COMPREHENSIVE)

Relative potency equivalents of the typical (first-generation) antipsychotics, referenced to 100 mg chlorpromazine, with the potency-side-effect relationship. For revision and rough dose comparison only.

Chlorpromazine-Equivalent Doses

Agent	Approx. Equivalent Dose
Chlorpromazine (Thorazine)	100 mg (reference); low potency
Thioridazine (Mellaril)	~100 mg; low potency; highest anticholinergic, QTc warning
Mesoridazine (Serentil)	~50 mg; QTc warning
Molindone (Moban)	~10 mg; only typical reported not to cause weight gain
Loxapine (Loxitane)	~10 mg; metabolite is amoxapine
Perphenazine (Trilafon)	~8-10 mg; mid-potency (the CATIE comparator)
Trifluoperazine (Stelazine)	~5 mg; also has an anxiolytic indication
Thiothixene (Navane)	~4-5 mg; high potency
Haloperidol (Haldol)	~2 mg; high potency, high EPS, low anticholinergic/sedation
Fluphenazine (Prolixin)	~2 mg; high potency, high EPS; available as depot

NOTE The classic potency ladder runs from low-potency chlorpromazine/thioridazine (~100 mg) to high-potency haloperidol/fluphenazine (~2 mg) - a roughly 50-fold range in milligram potency.

Potency-Side-Effect Relationship

Principle	Detail
Potency vs efficacy	Potency = dose needed for effect (NOT a measure of how effective); all typicals are similarly efficacious at equivalent doses
Low-potency profile	Lower doses of D2 blockade but MORE anticholinergic, antihistaminic (sedation/weight gain), and alpha-1 (postural hypotension); LESS EPS
High-potency profile	MORE EPS and hyperprolactinaemia; LESS anticholinergic, sedation, and hypotension
D2 occupancy threshold	65-78% striatal D2 blockade needed to reduce psychosis; haloperidol 2-5 mg/day achieves this; >80% raises EPS risk

Principle	Detail
Relapse rates	With medication <30%/year; without medication 60-70% in 1 year, ~90% in 2 years

NOTE Potency predicts the side-effect profile, not efficacy: LOW-potency agents are more sedating, anticholinergic, and hypotensive but cause less EPS, while HIGH-potency agents cause more EPS and prolactin elevation but less sedation.

NOTE Antipsychotics must block 65-78% of striatal D2 receptors to treat psychosis - haloperidol 2-5 mg/day reaches this - and exceeding ~80% sharply increases extrapyramidal side effects without added benefit.

DSM-5 CRITERIA - QUICK REFERENCE TABLE (COMPREHENSIVE)

A rapid-revision table of DSM-5 diagnostic thresholds - symptom counts and duration criteria at a glance, across every major disorder group. Use alongside the detailed DSM-5 Criteria compilations. Always confirm against DSM-5-TR.

Depressive & Bipolar Disorders

Disorder	Symptom Threshold	Duration
Major Depressive Disorder	≥ 5 of 9 (SIGECAPS), ≥ 1 = mood/anhedonia	≥ 2 weeks
Persistent Depressive Disorder	Depressed mood + ≥ 2 of 6	≥ 2 yr (≥ 1 yr children)
DMDD	Severe temper outbursts ≥ 3 x/week + irritable between	≥ 12 months; onset < 10 ; dx 6-18
PMDD	≥ 5 symptoms (≥ 1 affective), final week before menses	≥ 2 symptomatic cycles
Manic Episode (Bipolar I)	Elevated/irritable mood + ≥ 3 of 7 (≥ 4 if irritable; DIGFAST)	≥ 1 week (or any if hospitalised)
Hypomanic Episode (Bipolar II)	Same + $\geq 3/4$; no marked impairment/psychosis	≥ 4 days
Cyclothymic Disorder	Hypomanic + depressive symptoms, sub-threshold	≥ 2 yr (≥ 1 yr children)

Schizophrenia Spectrum & Psychotic

Disorder	Symptom Threshold	Duration
Schizophrenia	≥ 2 of 5, ≥ 1 positive (delusion/hallucination/disorganised speech)	≥ 6 months total (≥ 1 mo active)
Schizophreniform	Schizophrenia criteria	1-6 months
Brief Psychotic Disorder	≥ 1 positive symptom, full recovery	> 1 day, < 1 month
Schizoaffective	Schizophrenia + mood episode; psychosis ≥ 2 wk without mood	Mood majority of illness
Delusional Disorder	≥ 1 delusion, function preserved	≥ 1 month
Catatonia	≥ 3 of 12 features	-

NOTE The psychotic disorders are separated purely by DURATION: brief psychotic (< 1 month) -> schizophreniform (1-6 months) -> schizophrenia (≥ 6 months) - a near-universal exam question.

Anxiety Disorders

Disorder	Symptom Threshold	Duration
Panic Disorder	Recurrent attacks (≥ 4 of 13 symptoms) + worry/change	≥ 1 month worry
Agoraphobia	Fear of ≥ 2 of 5 situations	≥ 6 months
GAD	Excessive worry + ≥ 3 of 6 (1 in children)	≥ 6 months
Social Anxiety Disorder	Fear of scrutiny in social situations	≥ 6 months
Specific Phobia	Marked fear of object/situation	≥ 6 months
Separation Anxiety	≥ 3 of 8 symptoms	≥ 4 wk children / ~ 6 mo adults
Selective Mutism	Failure to speak in specific situations	≥ 1 month (not 1st month school)

NOTE Anxiety duration thresholds cluster at ≥ 6 months (GAD, phobias, social anxiety, agoraphobia) except panic disorder (≥ 1 month of worry) and separation anxiety (≥ 4 weeks in children).

Obsessive-Compulsive & Related

Disorder	Symptom Threshold	Duration
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Disorder	Symptom Threshold	Duration
OCD	Obsessions and/or compulsions, time-consuming (>1 h/day)	-
Body Dysmorphic Disorder	Preoccupation w/ defect + repetitive behaviours	-
Hoarding Disorder	Difficulty discarding + accumulation/clutter	-
Trichotillomania	Recurrent hair-pulling + attempts to stop	-
Excoriation	Recurrent skin-picking + attempts to stop	-

Trauma & Stressor-Related

Disorder	Symptom Threshold	Duration
PTSD	Trauma + 4 clusters (intrusion/avoidance/cognition-mood/arousal)	>=1 month
Acute Stress Disorder	Same domains as PTSD	3 days - 1 month
Adjustment Disorder	Symptoms within 3 mo of stressor	Resolves <6 mo after stressor ends
Reactive Attachment Disorder	Inhibited/withdrawn; insufficient care	Before age 5
Disinhibited Social Engagement	Overfamiliar; insufficient care	Developmental age >=9 months

NOTE Acute stress disorder (3 days-1 month) and PTSD (>=1 month) cover the same symptom domains across different timeframes.

Feeding & Eating Disorders

Disorder	Symptom Threshold	Duration/Severity
Anorexia Nervosa	Restriction + low weight + fear + body image	Severity by BMI (mild >=17 to extreme <15)
Bulimia Nervosa	Binge + compensatory behaviours	>=1x/week x 3 months

Disorder	Symptom Threshold	Duration/Severity
Binge Eating Disorder	Binge, no compensation	≥ 1 x/week x 3 months
ARFID	Avoidance/restriction (not shape-driven) + nutrition impact	-
Pica	Eating non-food substances	≥ 1 month
Rumination	Repeated regurgitation	≥ 1 month

Substance, Neurodevelopmental, Neurocognitive & Other

Disorder	Symptom Threshold	Duration/Age
Substance Use Disorder	≥ 2 of 11 criteria (mild 2-3, mod 4-5, severe ≥ 6)	Within 12 months
ADHD	≥ 6 symptoms (≥ 5 if ≥ 17), several before age 12, ≥ 2 settings	≥ 6 months
Autism Spectrum Disorder	Social-communication deficits + ≥ 2 RRBs; levels 1-3	Early developmental period
Conduct Disorder	≥ 3 of 15 behaviours	≥ 12 months (1 in last 6 mo)
ODD	≥ 4 symptoms (angry/argumentative/vindictive)	≥ 6 months
Intermittent Explosive Disorder	Recurrent disproportionate outbursts	Age ≥ 6
Delirium	Acute attention/awareness disturbance, fluctuating	Hours to days
Major Neurocognitive Disorder	Significant decline, interferes with independence	-
Mild Neurocognitive Disorder	Modest decline, independence preserved	-
Somatic Symptom Disorder	≥ 1 somatic symptom + disproportionate response	Typically >6 months

Disorder	Symptom Threshold	Duration/Age
Illness Anxiety Disorder	Preoccupation w/ illness, minimal symptoms	≥ 6 months
Enuresis / Encopresis	Inappropriate voiding/soiling	Enuresis age ≥ 5 ; Encopresis ≥ 4

NOTE Substance use disorder severity is graded purely by criterion count out of 11: mild (2-3), moderate (4-5), severe (≥ 6).

DSM-5 DIAGNOSTIC CRITERIA - PART I: MOOD, PSYCHOTIC, ANXIETY, OCD, TRAUMA & DISSOCIATIVE (COMPREHENSIVE)

Detailed DSM-5 diagnostic criteria with full symptom lists, durations, thresholds, and specifiers. Part I of two, reviewed and expanded against DSM-5-TR. For revision; consult DSM-5-TR for complete wording.

Depressive Disorders

Disorder	Criteria, Thresholds & Specifiers
Major Depressive Disorder	≥ 5 of 9 (SIGECAPS + depressed mood) for ≥ 2 weeks, ≥ 1 being depressed mood OR anhedonia. Symptoms: depressed mood, anhedonia, weight/appetite change, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue, worthlessness/guilt, poor concentration, recurrent thoughts of death. Causes distress/impairment; no manic/hypomanic episode ever
Persistent Depressive Disorder (Dysthymia)	Depressed mood most days ≥ 2 years (≥ 1 year in children/adolescents) + ≥ 2 of: poor appetite/overeating, insomnia/hypersomnia, low energy, low self-esteem, poor concentration, hopelessness. Never symptom-free > 2 months; consolidates DSM-IV dysthymia + chronic MDD
Disruptive Mood Dysregulation Disorder (DMDD)	Severe recurrent temper outbursts (verbal/behavioural) grossly out of proportion, ≥ 3 x/week, in ≥ 2 settings, with persistently irritable/angry mood between outbursts. ≥ 12 months (no symptom-free period > 3 months); onset before 10; first dx between ages 6-18

Disorder	Criteria, Thresholds & Specifiers
Premenstrual Dysphoric Disorder (PMDD)	≥ 5 symptoms in final week before menses, improving within days of onset, minimal post-menses. ≥ 1 affective core (lability, irritability/anger, depressed mood, anxiety) + total ≥ 5 with behavioural/physical. Confirmed by prospective daily ratings over ≥ 2 cycles
Depressive specifiers	With anxious distress; mixed features; melancholic; atypical; psychotic (mood-congruent/incongruent); catatonia; peripartum onset; seasonal pattern. Severity: mild/moderate/severe

NOTE MDD = ≥ 5 of 9 symptoms for ≥ 2 weeks (≥ 1 being depressed mood or anhedonia). DSM-5 removed the bereavement exclusion, allowing MDD to be diagnosed during grief when full criteria are met.

NOTE DMDD (onset before 10, first diagnosed 6-18) was added to curb over-diagnosis of paediatric bipolar disorder - it is chronic irritability with frequent outbursts, NOT episodic mania.

Bipolar & Related Disorders

Disorder	Criteria, Thresholds & Specifiers
Bipolar I Disorder (Manic Episode)	Abnormally elevated/expansive/irritable mood + persistently increased energy/activity, ≥ 1 week (or any duration if hospitalisation needed), most of day nearly every day. ≥ 3 of 7 (≥ 4 if mood only irritable): grandiosity, decreased need for sleep, more talkative/pressured speech, flight of ideas/racing thoughts, distractibility, increased goal-directed activity/psychomotor agitation, excessive risky activities (DIGFAST). Marked impairment/hospitalisation/psychosis. Only ONE manic episode needed for the diagnosis
Bipolar II Disorder	≥ 1 hypomanic episode AND ≥ 1 major depressive episode; NEVER a full manic episode; causes distress/impairment (often from depression or unpredictability)
Hypomanic Episode	Same symptom set as mania, ≥ 4 consecutive days, observable change in functioning, BUT not severe enough to cause marked impairment/hospitalisation, and NO psychosis (psychosis = mania by definition)

Disorder	Criteria, Thresholds & Specifiers
Cyclothymic Disorder	Numerous periods of hypomanic & depressive symptoms (sub-threshold for full episodes) for ≥ 2 years (≥ 1 year in children); symptoms present $\geq$ half the time, never symptom-free > 2 months
Substance/Medication-Induced Bipolar	Prominent persistent mood disturbance during/soon after substance intoxication/withdrawal or medication exposure capable of producing it
Bipolar specifiers	With anxious distress, mixed features, rapid cycling (≥ 4 episodes/year), melancholic, atypical, psychotic, catatonia, peripartum onset, seasonal pattern

NOTE DSM-5 added 'increased energy/activity' as a core (gateway) criterion for mania/hypomania alongside mood; only ONE lifetime manic episode is required for bipolar I.

NOTE Mania vs hypomania = duration plus severity: mania ≥ 7 days (or any if hospitalised) or with psychosis; hypomania ≥ 4 days with no marked impairment, hospitalisation, or psychosis. DIGFAST gives the symptom count (≥ 3 , or ≥ 4 if irritable-only).

Schizophrenia Spectrum & Other Psychotic Disorders

Disorder	Criteria, Thresholds & Specifiers
Schizophrenia	≥ 2 of: (1) delusions, (2) hallucinations, (3) disorganised speech, (4) grossly disorganised/catatonic behaviour, (5) negative symptoms - each ≥ 1 month (active phase), with ≥ 1 being (1), (2), or (3). Continuous signs ≥ 6 months (may include prodromal/residual). Social/occupational dysfunction; schizoaffective & mood disorder with psychotic features excluded; not substance/medical
Schizophreniform Disorder	Schizophrenia symptom criteria, episode 1-6 months. 'Provisional' if diagnosed before recovery. Specify with/without good prognostic features (≥ 2 of: onset of psychosis within 4 weeks of behaviour change, confusion/perplexity, good premorbid function, absence of blunted/flat affect)

Disorder	Criteria, Thresholds & Specifiers
Schizoaffective Disorder	Uninterrupted period with a major mood episode CONCURRENT with schizophrenia criterion A; delusions/hallucinations for ≥ 2 weeks WITHOUT a major mood episode (lifetime); mood symptoms present for the MAJORITY of total illness. Bipolar type vs depressive type
Delusional Disorder	≥ 1 delusion ≥ 1 month; criterion A for schizophrenia never met; functioning not markedly impaired, behaviour not bizarre; any mood episodes brief relative to delusions. Types: erotomantic, grandiose, jealous, persecutory, somatic, mixed, unspecified; with bizarre content
Brief Psychotic Disorder	≥ 1 of delusions/hallucinations/disorganised speech/grossly disorganised or catatonic behaviour (≥ 1 must be a positive symptom), >1 day but <1 month, with full return to premorbid function. Specify: with/without marked stressor, peripartum onset, catatonia
Catatonia	≥ 3 of 12: stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, mannerism, stereotypy, agitation, grimacing, echolalia, echopraxia. May be associated with another mental disorder, a medical condition, or unspecified
Other Specified (psychotic)	Persistent auditory hallucinations alone; attenuated psychosis syndrome; delusional symptoms in partner of an individual with delusional disorder (folie a deux)

NOTE DSM-5 removed the classic schizophrenia subtypes (paranoid, hebephrenic, etc.) and the special weighting of bizarre delusions/Schneiderian symptoms; now ≥ 2 symptoms are needed, at least one positive.

NOTE Schizoaffective disorder requires ≥ 2 weeks of psychosis WITHOUT mood symptoms (lifetime) plus mood symptoms for the majority of the illness - distinguishing it from a mood disorder with psychotic features.

Anxiety Disorders

Disorder	Criteria, Thresholds & Specifiers
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Disorder	Criteria, Thresholds & Specifiers
Panic Disorder	Recurrent UNEXPECTED panic attacks (abrupt surge peaking within minutes, ≥ 4 of 13 symptoms: palpitations, sweating, trembling, dyspnoea, choking, chest pain, nausea, dizziness, chills/heat, paraesthesia, derealisation, fear of losing control, fear of dying) + ≥ 1 month of persistent concern or maladaptive behaviour change
Agoraphobia	Marked fear of ≥ 2 of 5: public transport, open spaces, enclosed spaces, queues/crowds, being outside home alone. Situations avoided/endured with distress, out of proportion, ≥ 6 months
Generalized Anxiety Disorder	Excessive anxiety/worry most days ≥ 6 months, difficult to control + ≥ 3 of 6: restlessness, easily fatigued, poor concentration, irritability, muscle tension, sleep disturbance (only 1 needed in children)
Specific Phobia	Marked fear/anxiety about a specific object/situation, actively avoided, out of proportion, ≥ 6 months. Types: animal, natural environment, blood-injection-injury, situational, other
Social Anxiety Disorder	Marked fear of ≥ 1 social situation with possible scrutiny; fears negative evaluation/offending others; situations avoided; out of proportion; ≥ 6 months. Specify performance-only. In children must occur in peer settings
Separation Anxiety Disorder	Developmentally inappropriate fear of separation, ≥ 3 of 8 (distress at separation, worry about losing/harm to attachment figures, reluctance to go out, fear of being alone, refusal to sleep away, nightmares, somatic complaints). ≥ 4 weeks children, typically ≥ 6 months adults
Selective Mutism	Consistent failure to speak in specific social situations despite speaking elsewhere; interferes with achievement/communication; ≥ 1 month (not limited to first month of school)

NOTE DSM-5 separated agoraphobia, specific phobia, and social anxiety as independent diagnoses each requiring ≥ 6 months (in all ages), and moved OCD and PTSD OUT of the anxiety chapter.

Obsessive-Compulsive & Related Disorders

Disorder	Criteria, Thresholds & Specifiers
Obsessive-Compulsive Disorder	Obsessions (recurrent, persistent, intrusive, unwanted thoughts/urges/images causing anxiety, which the person attempts to ignore/suppress/neutralise) AND/OR compulsions (repetitive behaviours/mental acts performed by rigid rules to reduce distress/prevent a feared event, not realistically connected or clearly excessive). Time-consuming (>1 h/day) or distressing. Specify insight (good/fair, poor, absent/delusional); tic-related
Body Dysmorphic Disorder	Preoccupation with ≥ 1 perceived defect not observable/slight to others + repetitive behaviours (mirror checking, grooming, skin-picking, reassurance) or mental acts (comparing). Specify with muscle dysmorphia; insight
Hoarding Disorder	Persistent difficulty discarding possessions regardless of value, due to a perceived need to save + distress discarding; accumulation congests/clutters living areas. Specify with excessive acquisition; insight
Trichotillomania	Recurrent hair-pulling causing hair loss + repeated attempts to decrease/stop
Excoriation (Skin-Picking)	Recurrent skin-picking causing lesions + repeated attempts to decrease/stop
Cultural/Other Specified	Shubo-kyofu (fear of bodily deformity); koro; jikoshu-kyofu (olfactory reference - fear of offensive body odour); obsessional jealousy; body-focused repetitive behaviour disorder

NOTE The OCD-related chapter (new in DSM-5) groups OCD, BDD, hoarding, trichotillomania, and excoriation, all sharing an insight specifier (good/fair, poor, or absent/delusional).

Trauma & Stressor-Related Disorders

Disorder	Criteria, Thresholds & Specifiers
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Disorder	Criteria, Thresholds & Specifiers
Post-Traumatic Stress Disorder (adult)	Exposure to actual/threatened death, serious injury, or sexual violence (direct, witnessed, learning of, or repeated/extreme exposure to aversive details) + 4 clusters: (B) intrusion (memories, nightmares, flashbacks, distress/reactivity to cues), (C) avoidance, (D) negative alterations in cognitions/mood, (E) marked alterations in arousal/reactivity. ≥ 1 month. Specify with dissociative symptoms; with delayed expression
PTSD preschool subtype	Separate criteria for children ≤ 6 years
Acute Stress Disorder	Exposure as in PTSD + ≥ 9 symptoms across intrusion/negative mood/dissociation/avoidance/arousal, lasting 3 days to 1 month after trauma
Adjustment Disorders	Emotional/behavioural symptoms within 3 months of an identifiable stressor, out of proportion/causing impairment; resolves within 6 months of the stressor (or its consequences) ending. Subtypes: depressed mood, anxiety, mixed anxiety & depression, conduct disturbance, mixed emotions & conduct
Reactive Attachment Disorder	Consistent inhibited, emotionally withdrawn behaviour toward caregivers (rarely seeks/responds to comfort) + persistent social/emotional disturbance, following grossly insufficient care (pattern of extremes); developmental age ≥ 9 months; evident before age 5
Disinhibited Social Engagement Disorder	Pattern of actively approaching/interacting with unfamiliar adults (reduced reticence, overfamiliarity, willingness to go off with a stranger), following grossly insufficient care; developmental age ≥ 9 months
Prolonged Grief Disorder (DSM-5-TR)	Persistent intense grief ≥ 12 months (≥ 6 months in children) after a death, with intense yearning or preoccupation + ≥ 3 of 8 symptoms (disbelief, intense emotional pain, identity disruption, avoidance, numbness, loneliness, meaninglessness, difficulty reintegrating)

NOTE PTSD now has four symptom clusters (intrusion, avoidance, negative cognitions/mood, arousal), a preschool subtype, and a dissociative subtype; prolonged grief disorder was added in DSM-5-TR (2022).

Dissociative Disorders

Disorder	Criteria, Thresholds & Specifiers
Dissociative Identity Disorder	Disruption of identity with ≥ 2 distinct personality states (or experience of possession) + recurrent gaps in recall of everyday events/personal information/trauma inconsistent with ordinary forgetting; not part of accepted cultural/religious practice
Dissociative Amnesia	Inability to recall important autobiographical (usually traumatic/stressful) information, too extensive for ordinary forgetting (localised, selective, or generalised). Specify with dissociative fugue (purposeful travel/bewildered wandering with amnesia)
Depersonalization/Derealization Disorder	Persistent/recurrent depersonalisation (unreality/detachment from self) and/or derealisation (unreality/detachment from surroundings); reality testing remains INTACT throughout

NOTE Depersonalization/derealization disorder is defined by INTACT reality testing - the person knows the experience is not real - separating it from a psychotic disorder.

DSM-5 DIAGNOSTIC CRITERIA - PART II: EATING, SUBSTANCE, NEURODEVELOPMENTAL, NEUROCOGNITIVE, IMPULSE & SOMATIC (COMPREHENSIVE)

Detailed DSM-5 diagnostic criteria with full symptom lists, durations, thresholds, and specifiers. Part II of two, reviewed and expanded against DSM-5-TR. For revision; consult DSM-5-TR for complete wording.

Feeding & Eating Disorders

Disorder	Criteria, Thresholds & Specifiers
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Disorder	Criteria, Thresholds & Specifiers
Anorexia Nervosa	(A) Restriction of energy intake -> significantly low body weight for age/sex/health. (B) Intense fear of weight gain or persistent behaviour interfering with weight gain. (C) Disturbance in body-weight experience / undue influence on self-evaluation / lack of recognition of seriousness. Types: restricting; binge-eating/purging. Severity by BMI: mild ≥ 17 , moderate 16-16.99, severe 15-15.99, extreme < 15
Bulimia Nervosa	Recurrent binge eating (eating an objectively large amount + sense of loss of control) + recurrent inappropriate compensatory behaviours (self-induced vomiting, laxatives/diuretics, fasting, excessive exercise), both ≥ 1 x/week for ≥ 3 months; self-evaluation unduly influenced by shape/weight; not exclusively during anorexia. Severity by episodes/week
Binge Eating Disorder	Recurrent binge eating with marked distress + ≥ 3 of: eating rapidly, eating until uncomfortably full, eating when not hungry, eating alone from embarrassment, feeling disgusted/guilty. ≥ 1 x/week for ≥ 3 months; NO regular compensatory behaviour
ARFID	Avoidance/restriction of food intake (lack of interest, sensory aversion, or fear of aversive consequences) -> significant weight loss, nutritional deficiency, dependence on supplements/enteral feeding, or psychosocial impairment; NOT driven by weight/shape concern
Pica	Persistent eating of non-nutritive, non-food substances ≥ 1 month, developmentally inappropriate, not culturally sanctioned (minimum developmental age ~ 2 years)
Rumination Disorder	Repeated regurgitation of food (re-chewed, re-swallowed, or spat out) ≥ 1 month, not due to a GI/medical condition

NOTE DSM-5 removed the amenorrhoea criterion for anorexia, added severity grading by BMI (mild ≥ 17 to extreme < 15), and formally introduced binge eating disorder and ARFID as distinct diagnoses.

Elimination Disorders

Disorder	Criteria, Thresholds & Specifiers
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Disorder	Criteria, Thresholds & Specifiers
Enuresis	Repeated voiding of urine into bed/clothes (involuntary or intentional), ≥ 2 x/week for ≥ 3 consecutive months OR clinically significant distress/impairment; chronological (or developmental) age ≥ 5 . Subtypes: nocturnal only, diurnal only, nocturnal and diurnal
Encopresis	Repeated passage of faeces into inappropriate places (involuntary or intentional), ≥ 1 x/month for ≥ 3 months; chronological (or developmental) age ≥ 4 . Specify with/without constipation & overflow incontinence

NOTE Minimum ages: enuresis requires age ≥ 5 (≥ 2 x/week for ≥ 3 months), encopresis requires age ≥ 4 (≥ 1 x/month for ≥ 3 months).

Substance-Related & Addictive Disorders

Disorder	Criteria, Thresholds & Specifiers
Substance Use Disorder (general)	Problematic pattern $\rightarrow \geq 2$ of 11 within 12 months: (1) larger amounts/longer than intended, (2) persistent desire/failed efforts to cut down, (3) much time obtaining/using/recovering, (4) craving, (5) failure of role obligations, (6) continued use despite social/interpersonal problems, (7) activities given up, (8) hazardous use, (9) use despite physical/psychological harm, (10) tolerance, (11) withdrawal. Severity: mild 2-3, moderate 4-5, severe ≥ 6
Tolerance & withdrawal caveat	Tolerance/withdrawal occurring during appropriate medical supervision do NOT count toward the diagnosis
Substance categories	Alcohol, caffeine (intoxication/withdrawal only - no use disorder), cannabis, hallucinogens (incl. PCP), inhalants, opioids, sedatives/hypnotics/anxiolytics, stimulants, tobacco, other/unknown

Disorder	Criteria, Thresholds & Specifiers
Gambling Disorder	Persistent problematic gambling -> ≥ 4 of 9 in 12 months: needs increasing amounts, restless/irritable cutting down, repeated failed attempts to stop, preoccupation, gambles when distressed, chases losses, lies, jeopardises relationships/job/opportunity, relies on others for money. The ONLY behavioural (non-substance) addiction in DSM-5

NOTE DSM-5 merged abuse and dependence into a single substance use disorder graded by an 11-criterion count (mild 2-3, moderate 4-5, severe ≥ 6), dropped 'legal problems', and added 'craving'. Gambling disorder is the only behavioural addiction.

Neurodevelopmental Disorders

Disorder	Criteria, Thresholds & Specifiers
Intellectual Disability	Deficits in intellectual functions (reasoning, problem-solving, abstract thinking) confirmed by assessment AND deficits in adaptive functioning across conceptual/social/practical domains, with onset during the developmental period. Severity (mild/moderate/severe/profound) based on ADAPTIVE functioning, not IQ
Communication Disorders	Language disorder; speech sound disorder; childhood-onset fluency disorder (stuttering); social (pragmatic) communication disorder
Autism Spectrum Disorder	(A) Persistent deficits in social communication/interaction across contexts (social-emotional reciprocity, nonverbal communication, relationships - all 3). (B) Restricted, repetitive behaviours ≥ 2 of: stereotyped/repetitive movements/speech, insistence on sameness/routines, highly restricted fixated interests, sensory hyper/hyporeactivity. Onset early developmental period. Severity Levels 1/2/3 by support needs; specify with/without intellectual or language impairment, catatonia

Disorder	Criteria, Thresholds & Specifiers
ADHD	Persistent inattention (≥ 6 of 9) and/or hyperactivity-impulsivity (≥ 6 of 9); ≥ 5 in each domain if age ≥ 17 . Several symptoms before age 12, in ≥ 2 settings, interfering with functioning. Presentations: combined, predominantly inattentive, predominantly hyperactive/impulsive. Comorbid ASD now allowed
Specific Learning Disorder	Difficulties learning/using academic skills ≥ 6 months despite intervention, in reading, written expression, or mathematics; substantially below age expectations; onset during school years. Specify severity mild/moderate/severe
Motor Disorders	Developmental coordination disorder; stereotypic movement disorder; tic disorders
Tic Disorders	Tourette's = ≥ 2 motor + ≥ 1 vocal tic (not necessarily concurrent), >1 year, onset <18 . Persistent (chronic) motor OR vocal tic disorder = one type only, >1 year. Provisional tic disorder = tics <1 year. All onset before age 18

NOTE DSM-5 merged the previous autistic/Asperger's/PDD diagnoses into a single autism spectrum disorder graded by support level (1-3); intellectual disability severity is now based on ADAPTIVE functioning rather than IQ score.

NOTE ADHD now requires onset before age 12 (raised from 7), allows comorbid autism, and lowers the adult threshold to 5 symptoms.

Neurocognitive Disorders

Disorder	Criteria, Thresholds & Specifiers
Delirium	(A) Disturbance in attention & awareness, (B) developing acutely (hours-days), fluctuating, (C) plus an additional cognitive disturbance, (D-E) evidence of a medical/substance cause. Subtypes: hyperactive, hypoactive, mixed
Major Neurocognitive Disorder	Significant cognitive decline in ≥ 1 domain (complex attention, executive function, learning/memory, language, perceptual-motor, social cognition), based on concern + objective testing, that INTERFERES with independence in everyday activities (needs assistance)

Disorder	Criteria, Thresholds & Specifiers
Mild Neurocognitive Disorder	Modest cognitive decline that does NOT interfere with independence (everyday activities preserved, though greater effort/compensation may be needed)
NCD aetiological subtypes	Alzheimer's disease, vascular, frontotemporal, Lewy bodies, Parkinson's disease, traumatic brain injury, HIV infection, substance/medication-induced, prion disease, Huntington's disease, another medical condition, multiple aetiologies

NOTE The major-versus-mild neurocognitive disorder distinction hinges on independence: MAJOR decline interferes with independence (needs assistance), while MILD does not - 'mild NCD' replaced the older concept of mild cognitive impairment.

Disruptive, Impulse-Control & Conduct Disorders

Disorder	Criteria, Thresholds & Specifiers
Oppositional Defiant Disorder	≥ 4 symptoms from angry/irritable mood, argumentative/defiant behaviour, or vindictiveness, ≥ 6 months, during interaction with ≥ 1 non-sibling. Severity by number of settings (mild 1, moderate 2, severe ≥ 3)
Conduct Disorder	≥ 3 of 15 behaviours in 12 months (≥ 1 in last 6 months) across aggression to people/animals, destruction of property, deceitfulness/theft, serious rule violations. Childhood-onset (<10) vs adolescent-onset vs unspecified; specify with limited prosocial emotions (callous-unemotional)
Intermittent Explosive Disorder	Recurrent failure to resist aggressive impulses: verbal/physical aggression ~ 2 x/week for 3 months (non-damaging), OR ≥ 3 damaging/injurious outbursts in 12 months; grossly disproportionate; not premeditated; chronological age ≥ 6
Kleptomania	Recurrent failure to resist stealing objects not needed for use/value, rising tension before, pleasure/relief during; not done out of anger/revenge/in response to a delusion

Disorder	Criteria, Thresholds & Specifiers
Pyromania	Deliberate purposeful fire-setting on ≥ 1 occasion, tension/arousal before, fascination/attraction to fire, pleasure/relief when setting fires; not for monetary gain, ideology, concealment, or in response to delusion

NOTE Kleptomania and pyromania share the impulse-control signature - mounting tension before, relief/pleasure during - and are excluded if the act is done for gain, anger, ideology, or in response to a delusion.

Somatic Symptom & Related Disorders

Disorder	Criteria, Thresholds & Specifiers
Somatic Symptom Disorder	≥ 1 distressing/disruptive somatic symptom + excessive thoughts/feelings/behaviours about the symptoms or associated health concerns (≥ 1 of: disproportionate persistent thoughts about seriousness, persistently high anxiety, excessive time/energy). Typically persistent (> 6 months). Specify with predominant pain; persistent; severity
Illness Anxiety Disorder	Preoccupation with having/acquiring a serious illness; somatic symptoms absent or mild; high health anxiety; excessive health-related behaviours OR maladaptive avoidance; ≥ 6 months. Care-seeking type vs care-avoidant type
Conversion Disorder (FND)	≥ 1 symptom of altered voluntary motor or sensory function + clinical findings of incompatibility with recognised neurological/medical conditions
Factitious Disorder	Falsification of physical/psychological signs or induction of injury/disease, deceptive, even without obvious external reward (vs malingering, which is for external gain and is NOT a mental disorder). Imposed on self or on another
Psychological Factors Affecting Other Medical Conditions	Psychological/behavioural factors adversely affect a medical condition (course, treatment, additional health risk)

NOTE DSM-5 reframed the somatoform disorders around POSITIVE psychological features (excessive thoughts/anxiety/behaviours) rather than medically-unexplained symptoms; factitious disorder (no external reward) is distinct from malingering (external gain, not a disorder).

OVERDOSE, TOXICOLOGY & EMERGENCY MANAGEMENT (COMPREHENSIVE)

Management of psychotropic overdoses, drug-induced emergencies, and toxicological presentations. Reflects UK practice; confirm against current local protocols (TOXBASE/BNF) before clinical use.

Overdose & Toxicology Protocols

Presentation	Management
Paracetamol - phase 1 (<4 h)	Blood levels not yet interpretable; acetylcysteine unnecessary/inappropriate
Paracetamol - phase 2 (4-8 h)	Obtain plasma concentration to decide if treatment needed
Paracetamol - phase 3 (>8 h)	'Blind' acetylcysteine if ingestion >150 mg/kg (less if at-risk); stop if level below threshold
Paracetamol - phase 4 (>24 h)	Acetylcysteine treats acute liver failure (not as antidote); check LFTs, PT, electrolytes, paracetamol level. Pseudo-allergic reactions 5-10% (antihistamines); nausea/vomiting ~25%
TCA overdose	Supportive measures then gastric decontamination; activated charcoal up to 12 h (TCAs slow gastric emptying); dysrhythmia -> sodium bicarbonate, then lidocaine if it fails; dialysis has NO role
Benzodiazepine overdose	Supportive therapy +/- gastric lavage; dialysis of limited value (large volume of distribution); flumazenil counteracts sedation (beware short half-life)
Anticholinergic delirium	IV physostigmine 0.5-2 mg (caution in the medically ill)
MAOI hypertensive crisis	Prevention: education, food-warning leaflets. Treatment: alpha-blockade with phentolamine/phenoxybenzamine; chlorpromazine a useful alternative
PCP intoxication	Benzodiazepines + supportive care; antipsychotics amplify hyperthermia/dystonia/anticholinergic effects & lower seizure threshold; haloperidol only for PCP psychosis if not hyperthermic

Presentation	Management
SIADH (drug-induced)	Develops within weeks of starting drug; fluid restriction; demeclocycline in some cases

NOTE In TCA overdose, cardiac dysrhythmia is treated with sodium bicarbonate (then lidocaine if that fails); dialysis has no role, and activated charcoal works up to 12 hours because TCAs slow gastric emptying.

NOTE In PCP intoxication, benzodiazepines are preferred because antipsychotics amplify hyperthermia, dystonia, and anticholinergic effects while lowering the seizure threshold - haloperidol is reserved for PCP psychosis only if the patient is not hyperthermic.

MOOD DISORDER MANAGEMENT - NICE & MAUDSLEY (COMPREHENSIVE)

Evidence-based management algorithms for mood disorders, drawn from NICE and Maudsley guidelines. Guidelines are updated regularly; confirm against the current editions before clinical use.

Bipolar & Depression Management

Scenario	Recommended Management
Mania/hypomania (NICE)	Stop antidepressant; offer antipsychotic (haloperidol, olanzapine, quetiapine, risperidone); if ineffective switch antipsychotic; then add lithium (or valproate). Do NOT offer lamotrigine for mania
Mania (Maudsley algorithm)	Stop antidepressants; antipsychotic, valproate (avoid in women of childbearing age), or lithium; combine if inadequate; short-term benzodiazepines considered in all cases
Mania in young people	Aripiprazole (up to 12 weeks) for moderate-severe mania in bipolar I, age ≥ 13 ; do NOT offer valproate to girls/young women
Bipolar depression (NICE)	Fluoxetine + olanzapine, OR quetiapine alone; if no response -> lamotrigine alone; psychological intervention specific to bipolar disorder

Scenario	Recommended Management
Bipolar depression (Maudsley)	1st quetiapine; 2nd lithium or valproate; 3rd lamotrigine; 4th antidepressant + mood stabiliser/antipsychotic (olanzapine+fluoxetine best-supported). Antidepressants 2nd/3rd line only - can worsen course
Bipolar long-term (NICE)	Lithium first-line; add valproate if ineffective; if lithium unsuitable use valproate or olanzapine (or quetiapine if effective in an episode)
Rapid cycling (NICE)	1st lithium + valproate together; 2nd lithium monotherapy; 3rd add lamotrigine to lithium/valproate
Psychotic depression	Antidepressant + antipsychotic first-line; emergency ECT if not eating/drinking
Antidepressant discontinuation	Usually mild, self-limiting over 1-2 weeks; education/reassurance; if severe restart and taper slowly, or switch to fluoxetine (long half-life) then withdraw

NOTE NICE and Maudsley diverge on bipolar depression: NICE favours fluoxetine+olanzapine or quetiapine, while Maudsley puts antidepressants 2nd/3rd line (they can worsen the course) with quetiapine first.

NOTE Lamotrigine is NOT for acute mania (NICE explicitly advises against it) - its role is in bipolar maintenance and bipolar depression; lithium remains the first-line long-term agent.

ANXIETY, OCD-SPECTRUM & OTHER MANAGEMENT (COMPREHENSIVE)

Evidence-based management of anxiety, trauma, OCD-spectrum, sexual, and related disorders, drawn from NICE and standard guidelines. Confirm against current editions before clinical use.

Anxiety, Trauma & Related Management

Disorder	Recommended Management
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Disorder	Recommended Management
PTSD (NICE)	No debriefing; watchful waiting if mild <4 weeks (follow-up within 1 month); trauma-focused CBT or EMDR for all; 8-12 weekly 90-min sessions; drugs not routine first-line (paroxetine/mirtazapine general; amitriptyline/phenelzine specialist-initiated); avoid relaxation as non-directed therapy
Panic disorder (NICE)	SSRIs first-line (licensed one); if fail -> imipramine or clomipramine; benzodiazepines, sedating antihistamines & antipsychotics should NOT be used; continue 6 months after optimal dose; switch class if no improvement at 12 weeks
PMS/PMDD	Mild: lifestyle, CBT, exercise, diet. Severe: SSRIs (response 60-90% vs 30-40% placebo); fluoxetine and sertraline most studied; fluoxetine appears most effective; can be luteal-phase dosed
Trichotillomania	Habit reversal (behavioural) + medication: identify pulling, substitute benign behaviours (squeeze a ball), apply barriers (gloves/hat)
Shared psychotic disorder (folie a deux)	Separate the two individuals first (delusion from dominant partner); if delusion persists in submissive partner after 1-2 weeks, add medication
Anorexia - agitation	Benzodiazepines (small doses) for agitation needing intervention; AVOID antipsychotics for agitation (cardiac risk); olanzapine/quetiapine have a role for weight gain & intrusive thoughts
Erectile dysfunction	1st: PDE-5 inhibitors (sildenafil, tadalafil, vardenafil), apomorphine, psychotherapy, vacuum device; 2nd: intracavernosal vasoactive injection (alprostadil, papaverine); 3rd: prosthesis, vascular surgery
Transsexualism	Real-life test $\geq$ 1 year living full-time in the new gender before surgery is considered

Disorder	Recommended Management
Pathological laughing/crying in MS	Amitriptyline 75 mg/day (66% respond); also amantadine, levodopa, SSRIs (citalopram commonly used)

NOTE NICE PTSD essentials: no debriefing, watchful waiting if mild and present <4 weeks, trauma-focused CBT or EMDR as the mainstay, and drugs (paroxetine/mirtazapine) only as a non-first-line option.

NOTE In panic disorder, benzodiazepines, sedating antihistamines, and antipsychotics should all be AVOIDED; SSRIs are first-line, with imipramine or clomipramine as second-line.

Dementia, Antipsychotic Effects & Delirium

Scenario	Recommended Management
Alzheimer's - mild-moderate (MMSE >20)	Structured group cognitive stimulation, irrespective of drug treatment
Alzheimer's - moderate (MMSE 10-20)	AChEIs (donepezil, galantamine, rivastigmine) - stabilise cognition, improve ADLs, reduce behaviour problems; pretreatment ECG; donepezil contraindicated in asthma, rivastigmine safe
Alzheimer's - severe (MMSE <10)	Memantine (NMDA antagonist, neuroprotective; 10 mg BD; half-life 60-100 h; non-hepatic metabolism); may help vascular dementia
Hyperprolactinaemia (antipsychotic)	Switch to a prolactin-sparing antipsychotic; OR add aripiprazole 3-6 mg/day (lowers prolactin); last option dopamine agonist (amantadine/bromocriptine - may worsen psychosis)
Metabolic syndrome monitoring	Glucose: OGTT/fasting glucose at baseline, 1 & 6 months for clozapine/olanzapine. Lipids: fasting at baseline, 3 months, annually. BMI/waist at each visit. Offer simvastatin 40 mg if >40 y with CVD risk
Metabolic - drug choice	Lower risk: aripiprazole, amisulpride, asenapine, ziprasidone. Higher risk: clozapine, olanzapine. Bupropion, metformin, topiramate may reduce weight

Scenario	Recommended Management
Delirium - non-pharmacological	Reorientation (clock, window), familiar objects, family involvement, consistent staff, normal sleep pattern, hydration, correct sensory deficits, avoid restraints & sensory deprivation, good lighting, mobilisation
Parkinson's hallucinations (NICE)	First reduce Parkinson's medication; start a cholinesterase inhibitor before antipsychotics; quetiapine if distressing/refractory; haloperidol CONTRAINDICATED (worsens parkinsonism)
Nicotine addiction	NRT (gum/patch/inhalation); bupropion (DA/NA reuptake inhibitor); varenicline (nicotinic partial agonist); rimonabant withdrawn (depression/suicidality)
Metabolic syndrome - general	Weight loss via 30 min walking/day + diet (low saturated fat & complex carbs); appetite suppressants, fibrates, statins, ACEi/ARBs, metformin, thiazolidinediones for symptoms

NOTE The MMSE-banded dementia algorithm: cognitive stimulation for mild-moderate (>20), AChEIs for moderate (10-20), and memantine for severe (<10) Alzheimer's disease..

About This Book

This anthology brings together a comprehensive collection of psychiatry revision compilations in a single structured reference. Each compilation condenses a specific topic into high-yield tables, diagnostic criteria, clinical pearls, and key facts designed for rapid review, efficient knowledge consolidation, and examination preparation.

The book is unique in its scope, containing more than 150 carefully curated psychiatry compilations. Each compilation is designed to provide concise yet comprehensive scientific information, allowing readers to quickly access essential concepts while maintaining academic depth and clinical relevance.

The material spans psychopharmacology and treatment, clinical psychiatry, epidemiology, psychotherapy, psychology, neuroscience, diagnostic classifications, and practical clinical reference tools. A dedicated section also includes DSM-5-TR diagnostic criteria and high-yield charts frequently encountered in clinical practice and board examinations.

This book serves as an invaluable resource for psychiatry residents, psychiatrists, mental health professionals, medical students, and clinicians preparing for board, membership, and specialty examinations. It is equally useful for rapid revision, structured learning, and day-to-day clinical reference.

How to Use This Book

Compilations are grouped into five major sections (see Contents). Each section begins with a brief orientation and is organized around quick-reference tables and concise summaries. Important facts and frequently examined concepts are highlighted throughout to facilitate rapid recall and exam-focused learning.

Important Note

Statistics, drug dosages, approvals, guideline recommendations, and diagnostic criteria may vary between sources and evolve over time. This book is intended as a revision and educational resource and should not be used as a substitute for clinical judgment, prescribing guidance, or official practice recommendations.

Readers should always verify information against the most current editions of the BNF, Kaplan, Osxfod, Maudsley Prescribing Guidelines, NICE Guidelines, DSM-5-TR, ICD-11, and relevant local protocols before making clinical decisions.

REFERENCES & FURTHER READING

Selected standard references and revision resources used in clinical psychiatry and postgraduate examination preparation (MRCPsych and equivalents). Always consult the most current editions, as guidance and criteria are periodically revised.

Core Reference Textbooks

- **Kaplan & Sadock's Synopsis of Psychiatry** - Sadock, Sadock & Ruiz (Wolters Kluwer). The standard comprehensive clinical reference.
- **Kaplan & Sadock's Comprehensive Textbook of Psychiatry** - the extended two-volume reference work.
- **New Oxford Textbook of Psychiatry** - Gelder, Andreasen, Lopez-Ibor & Geddes (Oxford University Press).
- **Shorter Oxford Textbook of Psychiatry** - Cowen, Harrison & Burns (Oxford University Press).
- **The Maudsley Prescribing Guidelines in Psychiatry** - Taylor, Barnes & Young (Wiley-Blackwell). Authority for dosing and prescribing.
- **Stahl's Essential Psychopharmacology** - Stephen M. Stahl (Cambridge University Press). Mechanisms of action and neuroscientific basis.
- **Stahl's Prescriber's Guide** - Stephen M. Stahl (Cambridge University Press).
- **Oxford Handbook of Psychiatry** - Semple & Smyth (Oxford University Press). Concise clinical handbook.
- **Companion to Psychiatric Studies** - Johnstone, Cunningham Owens, Lawrie et al. (Churchill Livingstone).
- **Symptoms in the Mind / Fish's Clinical Psychopathology** - Sims; Casey & Kelly. Descriptive psychopathology and phenomenology.
- **Lishman's Organic Psychiatry** - David & Fleming et al. The reference for neuropsychiatry.
- **Hales & Yudofsky's Textbook of Psychiatry** - American Psychiatric Publishing.

Classification Systems & Official Guidelines

- **DSM-5-TR** - Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Text Revision (American Psychiatric Association).
- **ICD-11** - International Classification of Diseases, 11th Revision (World Health Organization).
- **NICE Guidelines** - National Institute for Health and Care Excellence (UK clinical guidance).
- **BNF** - British National Formulary (Joint Formulary Committee).

NOTE DSM-5-TR (APA) and ICD-11 (WHO) are the two principal diagnostic systems; NICE, the BNF, and the Maudsley Guidelines are the principal UK sources for treatment and prescribing.

Question Banks & Examination Preparation

- **Get Through MRCPsych** - Paper A & B / CASC series (CRC Press / Taylor & Francis).
- **Pass the MRCPsych** - Practice questions for Papers A and B.

- **Revision Notes in Psychiatry** - Wong, Castle & others - widely used MRCPsych revision text.
- **SPMM Course / Notes** - popular MRCPsych high-yield revision and question resource.
- **Trickcyclists / Allilmenta MCQ resources** - commonly used online MRCPsych question banks.
- **EMQs and MCQs for the MRCPsych** - Oxford / Hodder Arnold question collections.
- **Pass the CASC for the MRCPsych** - clinical assessment of skills and competencies practice.
- **Examination Notes in Psychiatry** - Bird & Harrison; Buckley - classic exam preparation notes.
- **MCQs in Psychiatry for the MRCPsych** - single-best-answer and extended-matching practice.
- **USMLE / PRITE psychiatry question banks** - e.g. First Aid for Psychiatry, BoardVitals (for US board-style practice).

NOTE Question-bank wording and answer keys can differ from current guidelines; where a discrepancy arises, defer to the latest primary sources (DSM-5-TR, ICD-11, NICE, and the Maudsley Guidelines).

انتهى
لا تتسوني من صالح دعائكم

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